2017 Update: Monterey County Cultural Competence Plan Requirements

California Department of Mental Health Cultural Competence Plan Requirements

COVER SHEET

An original, three copies, and a compact disc of this report (saved in PDF [preferred] or Microsoft Word 1997-2003 format) due March 15, 2011, to:

Department of Mental Health
Office of Multicultural Services
1600 9th Street, Room 153
Sacramento, California 95814

Name of County: Monterey County Health Department

Name of County Mental Health Director: Amie Miller, Psy.D, MFT

Name of Contact: Christina Santana, MPH

Contact’s Title: Health Equity and Cultural Competency Coordinator

Contact’s Unit/Division: Planning, Evaluation and Policy Unit

Contact’s Telephone: 831.755.4588 Contact’s Email: Santanac@co.monterey.ca.us

CHECKLIST OF THE CULTURAL COMPETENCE PLAN REQUIREMENTS MODIFICATION (2010) CRITERIA

☐ CRITERION 1: COMMITMENT TO CULTURAL COMPETENCE
☐ CRITERION 2: UPDATED ASSESSMENT OF SERVICE NEEDS
☐ CRITERION 3: STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES
☐ CRITERION 4: CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM
☐ CRITERION 5: CULTURALLY COMPETENT TRAINING ACTIVITIES
☐ CRITERION 6: COUNTY’S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF
☐ CRITERION 7: LANGUAGE CAPACITY
CRITERION 8: ADAPTATION OF SERVICES
Monterey County Behavioral Health Bureau
Cultural Competence Plan Requirements

Table of Contents

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Page #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction:</td>
<td>3</td>
</tr>
<tr>
<td>Criterion 1: Commitment of Cultural Competence</td>
<td>5 – 18</td>
</tr>
<tr>
<td>Criterion 2: Updated Assessment of Service Needs</td>
<td>19 – 35</td>
</tr>
<tr>
<td>Criterion 4: Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System</td>
<td>63 – 71</td>
</tr>
<tr>
<td>Criterion 5: Culturally Competent Training Activities</td>
<td>72 – 81</td>
</tr>
<tr>
<td>Criterion 6: Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff</td>
<td>82 – 87</td>
</tr>
<tr>
<td>Criterion 7: Language Capacity</td>
<td>88 – 96</td>
</tr>
<tr>
<td>Criterion 8: Adaptation of Services</td>
<td>97 – 102</td>
</tr>
</tbody>
</table>
APPENDICES

Appendix A: Exhibit E ...........................................................................................................104
Appendix B: MHSA FY 2013-14 through 2016-17 Section D-2 WET .................................108
Appendix C: Access to Treatment Cards ...........................................................................115
Appendix D: Policy 451 ........................................................................................................116
Appendix E: Policy 452 ........................................................................................................118
Appendix F: Behavioral Health Mental Health Services Act FY 18-20 .........................120
Appendix G: Cultural Relevancy and Humility Committee (CRHC) Action Plan ........330
Appendix H: Behavioral Health Adult and Children’s Services: System of Care Brochure 380
Appendix I: Quality Improvement Workplan Fiscal Year 2017/2018 .........................388
Appendix J: MHSA Program Evaluation Structure ............................................................402
Introduction

The Monterey County Health Department (MCHD) values its diverse communities and is committed to providing culturally competent services. MCHD recognizes that the diverse cultural and linguistic backgrounds of Monterey County residents directly affect access to and utilization of prevention and wellness services. The MCHD Strategic Plan includes four guiding initiatives: (1) Empower the community to improve health and wellbeing; (2) Enhance community health and safety by emphasizing prevention; (3) And ensure access to culturally and linguistically appropriate customer-friendly services (4) Improve and align operational functions to meet current and developing population health needs.

MCHD’s Behavioral Health Bureau (BHB) provides screening and assessment services, out and in-patient services, group and individual mental health services, case management, crisis intervention, medication support, peer-to-peer support and other recovery services.

Services are provided in an array of clinical and non-clinical settings such as schools, home, transitional housing units, community health centers, juvenile halls and jails, treatment residency programs, and mental health facilities.

Monterey County is comprised of 12 cities and 22 unincorporated communities. Currently, Monterey County’s racial/ethnic population composition 57% Hispanic/Latino, 32% Non-Hispanic white, 6% Asian, 3% African American, and 3% other. Linguistically, English is the most common language spoken at home, followed by Spanish, an Asian/Pacific Islander language, and Indo-European languages.

Cultural Competency Plan

The development of this plan utilized data provided by the Behavioral Health Quality Improvement (QI) Team, the BHB Strategic Plan, the Mental Health Services Act (MHSA), the External Quality Review Report (EQRO) for FY 16-17, Community Services and Supports (CSS) and the Prevention and Early Intervention (PEI) Plan plus stakeholder input through the Cultural Relevancy and Humility Committee (CRHC).

Included in our Cultural Competence Plan Requirements (CCPR) are identified gaps in the availability of resources and strategies for delivering the most culturally responsive services to our diverse population. To address these gaps, we have identified community-based partners, opportunities for continuing staff education and development, and actions to reduce service disparity among the most vulnerable populations. This report includes data, events and activities through December 2017.
CRITERION I: COUNTY MENTAL HEALTH SYSTEM COMMITMENT TO CULTURAL COMPETENCE

I: COUNTY MENTAL HEALTH SYSTEM COMMITMENT TO CULTURAL COMPETENCE

A. Policies, procedures and practices that fully incorporate the recognition and value of racial, ethnic and cultural diversity within the County Mental Health System. The provision of effective, equitable, respectful, understandable and quality care and services responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other needs.

In addition to existing policies and procedures that reflect the BHB’s commitment to providing culturally competent services, BHB has implemented programs to further integrate equitable values and practices into the Bureau to best serve the diverse population of Monterey County. BHB has adopted the following definition of Cultural Competence: “Cultural Competence is a set of congruent practice skills, knowledge, behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers and professionals that enables a system, agency and their professionals and consumer providers to work effectively in cross-cultural situations (Cross et al).” This definition is represented in the Cultural Competence Exhibit E (Appendix A). Additional BHB policies essential to providing culturally and linguistically competent services are listed below, several of which are discussed in detail later in this report.

A full copy of BHB culturally relevant policies and procedures can be found at: [http://qi.mtyhd.org](http://qi.mtyhd.org)

- **Policy 108**: Medicaid and Managed Care Plan
- **Policy 109**: Contract Monitoring
- **Policy 126**: Posting of Grievance Process Procedure
- **Policy 128**: Beneficiary Problem Resolution Process (Grievance, Standard, Appeals, Expedited Appeals)
- **Policy 201**: Staff Training
- **Policy 207**: Continuing Education Credit
- **Policy 208**: ASAM Training
- **Policy 337**: Risk Assessment of Minors in Schools Settings
- **Policy 451**: Cultural and Linguistic Services
- **Policy 452**: Distribution of Translated Materials
- **Policy 458**: Service Delivery
- **Policy 460**: Mobile Crisis Services
- **Policy 499**: Continuum Care
- **Policy 500**: Consents for Psychotropic Medications
- **Policy 507**: Control of Benzodiazepines
**Policy 509:** Controlled Substance Utilization Review and Evaluation (CURES 2.0) and Prescription Drug Monitoring Program (PDMP)  
**Policy 510:** Medication Authorization for Dependent Children  
**Policy 726:** Coordination and Continuity of Care

BHB has actively cultivated partnerships that value cultural diversity. BHB has maintained effective partnerships with organizations that are connected to and serve the Hispanic/Latino, African American, Lesbian Gay Bisexual Transgender Queer (LBGTQ), and Homeless populations. While these agency partnerships provide representation of traditionally underserved or unserved populations, and continues to develop additional partnerships and practices to ensure access to appropriate services for all who require them. Some of these practices include:

- The incorporation of cultural competency requirements for BHB contracts (Exhibit E, Appendix A)  
- Incorporating a Community Partnership Planning process in the MHSA FY18-20 Expenditure Plan [https://www.co.monterey.ca.us/home/showdocument?id=46412](https://www.co.monterey.ca.us/home/showdocument?id=46412)  
- Cultural Relevancy and Humility Committee Action Plan development  
- The development of a five-year strategic plan which incorporated community input from diverse stakeholders [http://www.co.monterey.ca.us/home/showdocument?id=18612](http://www.co.monterey.ca.us/home/showdocument?id=18612)  
- The development of a local Master’s of Social Work (MSW) degree program, at California State University Monterey Bay (CSUMB) focused on developing a bilingual and bi-cultural regional workforce [https://csumb.edu/msw](https://csumb.edu/msw)  
- The development of a partnership with Clínica de Salud del Valle de Salinas, a Federally Qualified Health Center for extending behavioral health services to the rural and traditionally underserved or unserved areas of Monterey County [http://www.csvs.org/](http://www.csvs.org/)  
- The integration of mental health services into Monterey County Health Department’s Clinic Services

**II: County recognition, value and inclusion of racial, ethnic, cultural and linguistic diversity within system.**

**A. A description of practices and activities that demonstrate community outreach, engagement and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with mental health disparities; including, recognition and value of racial, ethnic, cultural and linguistic diversity within the system. That may include the solicitation of diverse input to local mental health planning processes and services development.**

Over the past year BHB has been intentional in reaching out to partners, residents of various ages and cultural backgrounds to learn about their service needs and preferences. This shift comes at a time when we recognize that more can be done to address inequities in our communities that could be, unknowingly to us, perpetuated by a “business as usual” model. BHB is building off the “Governing for Racial Equity” initiative, which has been prioritized by the Health Department and endorsed by the Monterey County Board of Supervisors. This initiative calls for looking at the unintentional consequences of policies and practices and their impact on communities of color to
identify areas of improvement, govern and allocate resources in an equitable way. This recognition supports BHB’s goals of reaching underserved communities in new and innovative ways, and it also supports staff’s participation in programs and projects that aim to advance equity among underserved communities. This intentional work supports BHB’s long history of including community voice in its initiatives and strategic plans. For example, in 2013 the BHB held focus groups and informal conversations for BHB’s strategic plan that included consumers and family members, community partners, public and nonprofit service providers, contractors, health department staff, and other community stakeholders. Facilitators worked with participants to identify and prioritize key areas of improvement.

The development of the 2014-2017 MHSA Plan provided another opportunity for community engagement, involving individuals, consumers, families and service providers. Adhering to a cultural competence standard set by BHB, an intentional outreach plan was developed to include the voices of those in the community that often go unheard. This included mental health clients and family members, residents of low-income communities, ethnic minorities, migrant and new immigrant populations, the LGBTQ community, and other traditionally marginalized and unserved populations, plus community-based organizations to participate in these initiatives.

More recently, in 2017 BHB engaged in two key initiatives that started the process to shift BHB programs and services towards equity. One initiative was the creation of the Community Planning Process (CPP) to inform the MHSA CY18-20 and the other initiative was the Cultural Competency Action Plan (CCAP) driven by the Cultural Relevancy and Humility Committee, which serves as BHB’s Cultural Competency Committee. Both initiatives reached out to communities and heard from residents across the cultural, ethnic and geographic landscape of the county.

The CPP had three aims to: 1) identify those individuals with persistent mental health issues in Monterey County that have not been served, or have be inadequately served, by pervious MHSA funded activities; 2) analyze the issues expressed during the CPP process in the content of MHSA funding competent guidelines and the MCBH strategic framework; and 3) assess opportunities to alter, expand or create MHSA programs to address the issues that emerged from the CPP process. Although the goal of the CPP was to inform the MHSA plan, BHB will use this framework to find new opportunities, expand and/or modify programs for clients in need of behavioral health services through-out the BHB system.

The CPP was carried out in three phases. First focus groups were held across the County, then one-to-one surveys were administered throughout the county, and in the last phase public comment was received on the FY18-20 MHSA 3-Year Program and Expenditure Plan, which included an evaluation component of the CPP.

---

1 For the purpose of this report MHSA 3-Year Plan activities completed in 2017 will be reported here, and activities proposed for 2018 will be reported in the 2018 CCPR.
Seven (7) focus groups were conducted in English and six (6) were conducted in Spanish. The groups were advertised and facilitated by local stakeholders and community partners. The table below demonstrates the diversity of focus group participants.

Table 1: Community Planning Process Participants

<table>
<thead>
<tr>
<th>Focus Group</th>
<th>Date</th>
<th>City &amp; Region</th>
<th>Population</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Epicenter</td>
<td>2/12/2017</td>
<td>Salinas</td>
<td>LGBTQ Teens and Adults</td>
<td>25</td>
</tr>
<tr>
<td>EnLace</td>
<td>2/17/2017</td>
<td>King City &amp; South County</td>
<td>Latina</td>
<td>50</td>
</tr>
<tr>
<td>Skittles Support Group at Main St. Middle School</td>
<td>2/15/2017</td>
<td>Soledad and South County</td>
<td>LGBTQ Teens</td>
<td>40</td>
</tr>
<tr>
<td>EnLace</td>
<td>2/23/2017</td>
<td>Castroville &amp; North County</td>
<td>Latino Families</td>
<td>15</td>
</tr>
<tr>
<td>Promotores, CCA</td>
<td>3/7/2017</td>
<td>Salinas</td>
<td>Promotores (Latino)</td>
<td>11</td>
</tr>
<tr>
<td>Secure Families Grp</td>
<td>3/7/2017</td>
<td>Salinas</td>
<td>MCBH Consumers</td>
<td>5</td>
</tr>
<tr>
<td>Recovery Task Force</td>
<td>3/16/2017</td>
<td>Salinas</td>
<td>Consumers</td>
<td>15</td>
</tr>
<tr>
<td>The Alliance on Aging</td>
<td>3/23/2017</td>
<td>Salinas</td>
<td>Older Adults</td>
<td>9</td>
</tr>
<tr>
<td>The Alliance on Aging</td>
<td>4/4/2017</td>
<td>Peninsula</td>
<td>Older Adults</td>
<td>15</td>
</tr>
<tr>
<td>Partners for Peace Youth Group</td>
<td>4/5/2014</td>
<td>Salinas</td>
<td>Latino Youth</td>
<td>20</td>
</tr>
<tr>
<td>Voices of the Voiceless</td>
<td>4/19/2017</td>
<td>Salinas</td>
<td>Systems Impacted Adults</td>
<td>10</td>
</tr>
<tr>
<td>Youth for Change, CCA</td>
<td>4/19/2017</td>
<td>Salinas</td>
<td>Latino Youth</td>
<td>10</td>
</tr>
<tr>
<td>Chinatown Learning Center, Interim Inc</td>
<td>6/13/2017</td>
<td>Salinas</td>
<td>Homeless Adults</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>TOTAL</strong></td>
</tr>
</tbody>
</table>

Extensive analysis of services data from BHB Data Driven Decision FY 2017-17 (D3) show a lower service percent value provided to Hispanic/Latinos compared to other ethnic groups in relation to the number of clients being served across BHB programs. To get further clarity on this, the CPP administered a survey in zip codes with high Latino resident population and low services penetration rates. The goal of the survey was to understand how to better engage Latinos and increase the quality of behavioral health services to them. There was a total of 214 respondents to the survey.
To ensure cultural inclusion of our diverse county resident needs, the Cultural Relevancy and Humility Committee CRHC (serves as the BHB Cultural Competency Committee) also initiated a community assessment process to inform an Action Plan inclusive of racial, ethnic, cultural and linguistic communities. The overarching goal of the Action Plan was to “meet people where they are” and allow them to tell their story and their concerns as marginalized and underserved populations. Similarly, to the MHSA 3-Year Program and Expenditure Plan, the CRHC identified populations due to their need for service coordination and linkage. The CRHC collected data in focus groups, key one-to-one interviews, and surveys. The outreach process was conducted with CRHC members, community organizations and partners known and trusted by members of our underserved and unserved communities. Meeting locations were in familiar, comfortable and safe locations for each of the respective communities.

Below is a table with participant information.

Table 2: Cultural Competency Action Plan Participants

<table>
<thead>
<tr>
<th>Focus Group</th>
<th>Date</th>
<th>Location</th>
<th>City &amp; Region</th>
<th>Population</th>
<th>Number of Participants</th>
<th>Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American/Black</td>
<td>2/22/2017</td>
<td>Church</td>
<td>Salinas</td>
<td>African American</td>
<td>8</td>
<td>English</td>
</tr>
<tr>
<td>Asian American/Pacific Islander</td>
<td>4/3/2017</td>
<td>Interim</td>
<td>Salinas</td>
<td>Asian (Guam, Filipino, Japanese, Mixed Race (Black and Japanese))</td>
<td>7</td>
<td>English</td>
</tr>
<tr>
<td>Homeless/Displaced</td>
<td>2/2/2017</td>
<td>Interim</td>
<td>Salinas</td>
<td>Homeless/Displaced</td>
<td>10</td>
<td>English</td>
</tr>
<tr>
<td>LGBTQ</td>
<td>1/12/2017</td>
<td>Epi Center</td>
<td>Salinas</td>
<td>Youth &amp; Adults</td>
<td>12</td>
<td>English</td>
</tr>
<tr>
<td>LGBTQ</td>
<td>1/12/2017</td>
<td>Epi Center</td>
<td>Salinas</td>
<td>Youth &amp; Adults</td>
<td>8</td>
<td>Spanish</td>
</tr>
<tr>
<td>LGBTQ</td>
<td>2/15/2017</td>
<td>School</td>
<td>Soledad</td>
<td>Youth</td>
<td>18</td>
<td>English</td>
</tr>
<tr>
<td>System Impacted Families</td>
<td>3/15/2017</td>
<td>Church</td>
<td>Salinas</td>
<td>Families impacted by several “systems” *</td>
<td>15</td>
<td>English</td>
</tr>
<tr>
<td>Spanish-Speaking / Farmworkers</td>
<td>3/13/2017</td>
<td>CCA</td>
<td>Salinas</td>
<td>Latino</td>
<td>12</td>
<td>Spanish</td>
</tr>
<tr>
<td>BHB Staff</td>
<td>4/17/2017</td>
<td>Health Department</td>
<td>Salinas</td>
<td>BH Staff</td>
<td>19</td>
<td>English</td>
</tr>
</tbody>
</table>

*Focus Grp. Participant total: 109
### Key Informant Participants

<table>
<thead>
<tr>
<th>Key Informant</th>
<th>Date</th>
<th>Location</th>
<th>City &amp; Region</th>
<th>Population</th>
<th>Number of Participants</th>
<th>Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deaf and Hard of Hearing</td>
<td>4/3/2017</td>
<td>Community</td>
<td>Salinas</td>
<td>Deaf and Hard of Hearing</td>
<td>1</td>
<td>Sign Language</td>
</tr>
<tr>
<td>Filipino Male</td>
<td>4/5/2017</td>
<td>Community</td>
<td>Salinas</td>
<td>Asian</td>
<td>1</td>
<td>English</td>
</tr>
<tr>
<td>African American Male</td>
<td>3/24/2017</td>
<td>Community</td>
<td>Seaside</td>
<td>African American</td>
<td>1</td>
<td>English</td>
</tr>
<tr>
<td>African American Female</td>
<td>3/24/2017</td>
<td>Community</td>
<td>Seaside</td>
<td>African American</td>
<td>1</td>
<td>English</td>
</tr>
<tr>
<td>Japanese Male</td>
<td>4/6/2017</td>
<td>Community</td>
<td>Salinas</td>
<td>Asian</td>
<td>1</td>
<td>English</td>
</tr>
<tr>
<td>Japanese Female</td>
<td>4/7/2017</td>
<td>Community</td>
<td>Salinas</td>
<td>Asian</td>
<td>1</td>
<td>English</td>
</tr>
<tr>
<td>System Impacted</td>
<td>4/4 &amp; 4/10</td>
<td>Community</td>
<td>Salinas</td>
<td>System Impacted Families</td>
<td>2</td>
<td>English</td>
</tr>
<tr>
<td>BHB Staff</td>
<td>3/15 &amp; 3/16</td>
<td>Staff</td>
<td>Salinas</td>
<td>BH Staff</td>
<td>2</td>
<td>English</td>
</tr>
</tbody>
</table>

**Key Informant Participant total:** 10

### Survey Participants

<table>
<thead>
<tr>
<th>Survey Participants</th>
<th>Date</th>
<th>Location</th>
<th>City &amp; Region</th>
<th>Population</th>
<th>Number of Participants</th>
<th>Language</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2/25/2017</td>
<td>Community</td>
<td>Seaside, North County &amp; Salinas</td>
<td>African American</td>
<td>22</td>
<td>English</td>
</tr>
</tbody>
</table>

**Survey Participant total:** 22

**Participant Total:** 141

*Systems is referring to systems of poverty, homelessness, housing, incarceration, DSS, housing authority*
These initiatives further BHB’s commitment to engage community at multiple levels, it also ensures that BHB’s understands perspectives from various communities. The involvement with community is a small step to understand and begin to value the inclusion of the vast cultural diversity within our County.

**B. A narrative description addressing the county’s current relationship with, engagement with, and involvement of, racial, ethnic, cultural, and linguistically diverse clients, family members, advisory committees, local mental health boards and commissions, and community organizations in the mental health system’s planning process for services.**

Each annual funding request and progress report is developed and distributed for review and comment by respective workgroups or committees. The MHSA webpage on Monterey County’s website distributes information for the minimum 30-day public comment period. The document, depending upon the format, is translated into Spanish (English and Spanish are threshold languages for Monterey County) for posting through email and distribution at meetings. Input is solicited from the community via various email distribution lists. Announcements regarding the development of the draft and the public-comment period are made at MHSA component workgroups, committees, public forums, as well as at consumer and youth & family advisory council meetings.

All inquiries and comments about draft documents are collected by the MHSA Coordinator for inclusion in a report to the Mental Health Commission, which is part of the public hearing process. All comments received are included before the document is finalized and submitted to the California Department of Public Health, Mental Health Services Division.

Stakeholder involvement in the community program planning process occurs at several levels, including:

- Recovery Task Force
- Cultural Relevancy and Humility Committee
- Monterey County Mental Health Commission, South County Services Subcommittee
- Monterey County Mental Health Commission
- Monterey County Board of Supervisors, including Health & Human Services and Budget Committees
- Mental Health and Alcohol/Drug Service Providers
- Community-based service organizations
- Consumers, youth, family members, advocates and cultural brokers
- Social & Employment Services, i.e. Child Welfare and Employment & Training
- Law Enforcement and the Courts
- Education
- Labor
- Community Health and Primary Care
- Monterey County Health Department Planning, Evaluation, and Policy staff
Information regarding implementation of Monterey County’s major plans are shared with stakeholders in the following ways:

- Regular postings on the MHSA website
- Monthly reports to the Monterey County Mental Health Commission
- Distribution and posting of plan updates and funding augmentation requests
- Reports to the Monterey County Board of Supervisors and Chief Administrative Office
- Community meetings
- MHSA newsletters
- Presentations at meetings convened by other collaborative partners
- Presentations at staff meetings and leadership trainings
- Postings of flyers at clinics and other service sites
- Press releases and public service announcements
- News articles

As mentioned above, the CCAP was informed by multiple meetings with community members, consumer and family-member of consumers, agencies, and BHB staff. The CCAP was presented at the BHB managers meeting, Mental Health Commission and other community meetings. The CCAP identified three overarching priority areas to address the themes identified from the community. Priority areas include: 1) Improve Equity, 2) Strengthen Collaboration and Partnership and 3) Institutionalize Cultural Relevancy Practice/Perspective. Each of the priority areas specifies a focus area and action activates to support moving towards equity in BHB services with community input. Please see Exhibit G in Appendix A for the entire report.

Additional efforts to obtain feedback regarding BHB programs and services are ongoing through a well-developed social marketing campaign, coordinated by the MHSA funded Prevention and Early Intervention (PEI) Coordinator. In addition, BHB is actively engaged in community-based initiatives, such as the East Salinas Building Healthy Communities Initiative, sponsored by The California Endowment (TCE). East Salinas, an area of predominantly migrant populations within the City of Salinas, was chosen as one of 14 communities in the state to receive a 10-year investment to help reduce disparities in the areas of health, income, and education. BHB’s participation in this and other similar community initiatives provides the opportunity to align BHB services to activities that meet the needs identified by the community. This is another example how BHB can increase culturally relevant services to areas in the county that are underserved.

C. A narrative description discussing how the county is working on skills development and strengthening of community organizations involved in providing essential services.

BHB’s Cultural Relevancy and Humility Committee (CRHC) focuses on supporting the cultural and linguistic needs of Monterey County’s BHB diverse populations. All contract agencies are invited to participate in the CRHC and sit, alongside consumers and mental-health advocates to discuss how to improve service delivery. Meeting notes, agendas, and minutes are regularly
distributed through email regarding activities, issues and reports central to cultural competence development.

In FY 16-17 BHB continued a partnership with community organizations that work in and provide services to unserved and marginalized communities that have traditionally been underserved, such as African American, Latinos and LGBTQ communities. BHB expects to continue this work in the upcoming year with community agencies, such as Interim Inc., Epicenter, Center for Community Advocacy, The Village Project and Community Human Services, to name a few.

As part of the CRHC, BHB has sponsored trainings for community organizations raising issues around Hispanic/Latino health and how to support the development of culturally competent systems for the underserved was the focus in the September 2015 with Dr. Jose Angel Gutierrez as the guest presenter. BHB has also held movie screenings and community conversations with experts to explore health issues affecting the LGBTQ community, and those who suffer from PTSD. In July 2016, a cultural competency training was offered to organizations working with the LGBTQ community.

BHB reaches community-based organizations through e-mails, social media posts, announcements in local news media regarding cultural competency training opportunities. BHB encourages community based organizations providing essential services to participate in these and other training opportunities on cultural competency, service access, and narrowing the disparity gap among underserved and unserved populations. Workforce Education & Training Program trainings will be detailed later in this document.

**D. Share lessons learned on efforts made on the items A, B, and C above.**

Lessons learned from training programs and services developed for culturally diverse populations include:

- Outreach and engagement strategies for ethnically diverse, underserved and unserved communities take time, using innovative and non-traditional approaches.
- Building and developing relationships between consumers and the organizations that provide essential services should be on a constant continuum.
- Issues and concerns of diverse populations should be addressed in a meaningful way through innovative and evidence-based programs.
- Relationships with cultural brokers should be developed and nurtured. They can assist in engaging diverse populations and should be stakeholders in the planning, design and implementation of programs.
- When engaging the community, there should be consideration of interventions appropriate to the cultural and diversity of the groups that make up the community.
- Meetings, trainings and engagement opportunities should be conducted in the communities of those populations for which the programs are designed, and in their preferred language.
In addition to the lessons learned mentioned above, the CRHC committee identified five broad performance areas to use as a “road map” in BHB’s cultural competency efforts. These areas include:

- Communications
- Governance Issues
- Services and Interventions
- Infrastructure Issues
- Infusion of Values

In the future, CRHR and BHB may use these performance areas as a lens to review and revise culturally competent strategies, achieve program objectives, and determine how to best coordinate these efforts in the community.

**E. Identify county technical assistance needs.**

At this time, BHB does not require State technical assistance.

**III. EACH COUNTY HAS A DESIGNATED CULTURAL COMPETENCE/ETHNIC SERVICES MANAGER (CC/ESM) PERSON RESPONSIBLE FOR CULTURAL COMPETENCE**

**A. Evidence that the County Mental Health System has a designated CC/ESM who is responsible for cultural competence and who promotes the development of appropriate mental health services that will meet the diverse needs of the county’s racial, ethnic, cultural, and linguistic populations.**

In March of 2017 Christina Santana was hired as the Cultural Competence Coordinator. She sits under the Planning, Evaluation, and Policy (PEP) Unit and oversees the development of the CCPR and facilitates the CHRC meetings. Mrs. Santana also supports activities related to cultural competence and humility in service delivery. A Memorandum of Agreement between BHB and PEP is being finalized. Both PEP and the BHB will work to implement the CCPR and the Action Plan items. BHB representatives will co-facilitate the monthly CHRC meetings and provide quarterly updates to the committee about changes to any major plans, including but not limited to the Behavioral Health Strategic Plan and the Mental Health Services Act Plan.

**B. Written description of the cultural competence responsibilities of the designated CC/ESM.**

The Cultural Competency Coordinator carries the duties and responsibilities of supporting the implementation, maintenance, and evaluation of all the culturally competent services BHB offers. This position represents Monterey County on California’s Mental Health Directors Association Ethnic Services Committee, and the CRHC. These committees ensure that mental health services meet the needs of all individuals who seek such services, and that culture, language, ethnicity are reviewed and considered to provide high-quality service.
BHB understands that with the implementation of the Specialty Mental Health Services and MHSA, the state requires this classification to ensure that each county is monitoring/evaluating mental health services in accordance with the cultural competency plan. The Cultural Competency Coordinator serves to identify areas requiring improved service capacity, aid partner agencies with cultural competency plans, and provide consultations to better improve those plans. The position is essential in meeting the increased needs and demands of BHB programs, seeking to implement quality mental health services in a culturally diverse and sensitive manner.

IV. IDENTIFY BUDGET RESOURCES TARGETED FOR CULTURALLY COMPETENT ACTIVITIES; THE COUNTY SHALL INCLUDE THE FOLLOWING IN THE CCPR:

A. Evidence of a budget dedicated to cultural competence activities.

BHB’s FY 16-17 budget allocated $150,000 for overall training needs. Cultural competency trainings are focused on target populations identified in the Cultural Competency Plan Requirements (CCPR), PEI, and CCS Plans. Additional funding is allocated for contracting services with local agencies to train, educate, outreach and engage communities, and refer clients to mental health services.

B. Discussion of funding allocations included in the identified budget above in Section A, also including, but not limited to, the following:

1. Interpreter and translation services;

BHB seeks to recruit and hire bilingual employees. The number of employed bilingual staff is based on the number of qualified applicants. The budget allows for “bilingual pay” an additional pay to employees who pass a bilingual examination. The bilingual pay is added to their overall salary. This has served to attract more bilingual employees. Currently, 37% of the BHB workforce are receiving bilingual pay (158 out of 426 BHB employees). This percentage does not include service providers, which may have a higher percentage bilingual and bi-cultural staff that is, reflecting community’s demographics.

Despite these efforts to increase bilingual staff, there is still a need to better serve specific monolingual populations. Some of these needs are met through contracted services. BHB has a contract for interpretation services with the Natividad Medical Foundation to access their interpretation services for indigenous dialects, such as Mixteco and Triqui, which are of high incidence in the community. BHB has incorporated the use of telemedicine to meet language needs of those requiring immediate psychiatric services. BHB has contracted with USC bilingual therapists and psychiatrists to fill in gaps produced by our limited workforce gap. This service has been beneficial in reaching the Southern part of the County and for those clients that prefer this therapy option. Currently, all our clinics have computers and a space to hold private individual therapy sessions, and clients can come into the clinics and have their session there.
BHB also provides translated intake forms and program information in Spanish. These services are available at the time of client services and/or by client request.

2. Reduction of racial, ethnic, cultural, and linguistic mental health disparities;

BHB is the safety net for populations that do not have the financial means to attain medical care on their own, such as Medi-Cal beneficiaries and those living under the 200% poverty level. In Monterey County Latinos make up over 70% of the safety net population. Despite our best efforts, BHB is currently only serving 50% of the Latinos in Monterey County. Since 2009 the percentage of Latinos served by BHB has stayed between 53%-56% leaving a significant gap in service. Further, BHB’s EQRO 16-17 report shows the pattern of service for Medi-Cal beneficiaries, from this report, we can determine Latinos are being underserved by 18.4% (see table 6 for more details). To address this disparity the BHB has set the goal of increasing services to Latinos by 7% in 3 years. Over the last year BHB evaluated MHSA programs and made a conscious effort to increase services in underserved regions to support the goal of increasing Latino service delivery.

The BHB’s Mental Health Commission help guide the evaluation structure of all MHSA providers. The proposed structure was used to rank programs according to criteria such as addressing disparities, reaching the underserved and providing equitable services. The programs with the highest scores were more likely to be considered for funding in the FY18-20 cycle. Programs were rated on following eight criteria:

- Is this part of the MHSA Mandate?
- Does this program have a high clinical impact?
- Is this program part of addressing regional health inequity?
- Is this program part of increasing services to the Latino population?
- Is this program leveraging other resources (maximizing community impact with MHSA dollars)?
- Is this program cost effective?
- What is the level of contract performance?
- Could the program be funded by other sources?

The Commission members also discussed ways to go out into the community and engage in a dialogue about unmet needs; (See Appendix J for rating system) and supported the creation of the Community Process Planning (CPP). The CPP helped collect preliminary data from the Underserved Communities (by Zip Code) Survey, conducted by the Center for Community Advocacy, the Health Department’s enLACE program staff, and the PEI Coordinator, in the zip code areas where there are high concentrations of Latino residents who are not yet engaged in the community mental health system. This data was used to inform the MHSA FY 18-20 Expenditure Plan.
In addition to creating a structural change in program funding to support unserved and underserved community members, BHB has also contracted with various local community-based organizations in South County to expand early intervention, prevention ACCESS and residential treatment services for underserved and unserved residents. They include:

- **Kinship Center in South County Clinic**: This program is for children and youth in or transitioning to a permanent placement, with moderate to severe emotional and/or behavioral disturbances. (Early Intervention)
- **Senior Companion Program**: This program is for Older Adults (60+) clients with psychiatric disabilities residing in South County. (Prevention)
- **Senior Peer Counseling Programs/Fortaleciendo El Bienestar**: Older adults suffering from depression, anxiety, and adjustment disorders (Prevention)
- **NAMI Family Self Help Support and Advocacy**: This program is for adults (26-59) family and friends of people with mental illness (Outreach Early Signs)
- **Family Support Groups**: This program is for adults (26-59) and older adults (60+) who need additional support when mental illness is affecting their family’s functioning and quality of life. (Early Intervention)
- **Multi-lingual Parent Education Partnership**: This program is intended for Spanish speaking parents with young children. The program offers parents 8 to 10-week evidence based curriculum to increase parenting skills. (Early Intervention)
- **Promotores Mental Health Program**: This program uses Promotores to improve mental health awareness and access to services for Latino populations (Outreach Early Signs)
- **Secure Families/Familias Seguras**: This program is intended to serve children and youth to provide specialized mental health services for youth and children and their families. (Systems Development)
- **MCHOME**: This is a program intended for adults (26-59) with serious mental health illness and/or functioning limitations that substantially interfere with ability to carry out primary aspects of daily living in the community. Soledad House (in South County) serves as a transitional house for clients for no more than one year. (Residential Placement)
- **ACCESS Outpatient Services**: This program is for unserved or underserved clients with moderate to severe mental health issues of all ages. The program offers individual or family mental health counseling. (System Development)

BHB has been cognizant of about having programs that are culturally and linguistically appropriate for their target population and placing service providers who resemble the population in highly diverse areas, and is committed to hiring and retaining staff who are culturally competent, bilingual, and understand the needs of population they serve.

In addition to these services, in 2017 BHB received a six-million-dollar grant from proposition 47 to build the first outpatient residential treatment center in South County. BHB is slowing moving towards the goal of increasing 7% Latino clients in 3 years, these intentional efforts help support that goal.

3. Outreach to racial and ethnic county-identified target populations;
BHB has been intentional about reaching ethnic populations through their contracted services. For example, the Village Project serves African Americans, the Promotores program though the Center for Community Advocacy serves the immigrant monolingual Spanish speaking community, and the Epicenter serves the LGBT community to name a few. These partnerships with culture-specific agencies are developed to engage hard-to-reach populations experiencing service disparities. Each project combines outreach, education, and services aimed at improved service delivery. Projects are targeted to serve approximately 50 individuals/families per year, providing educational materials on common mental health diagnoses, such as depression and anxiety, plus information on coping skills, self-care and resources for seeking additional mental health services, as needed.

Along with traditional contracted providers, BHB psychiatrists have provided alternative-medicine services for interested consumers, including educational sessions on the use of natural healing practices. Further, BHB clinical staff provide early-intervention services in collaboration with primary-care providers.

Additionally, a full-time Chronic Disease and Prevention Coordinator (CDPC), Elizabeth Ambriz was hired in August 2014 to coordinate the Prevention and Early Intervention projects established by the Mental Health Services Act. Ambriz conducts a variety of community engagement and outreach activities, promoting mental health awareness and services, with a focus on unserved and underserved populations.

4. Culturally and linguistically appropriate mental health services;

All County and contracted services are required to move toward a continuum of culturally appropriate services. BHB contracts now include Exhibit E, a cultural competence policy that calls for culturally compliant services. These include offering services to underserved and unserved populations, making services available in the threshold languages and during hours that are convenient for the target populations. BHB also extends cultural competency training requirement to all staff.

5. If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers.

Currently, county staff who meet the bilingual requirements and can pass a proficiency test are eligible to receive additional pay for this skillset. In addition, Monterey County Health Department is considering developing a community health worker certification program, which may potentially increase the pool of culturally competent and linguistically diverse staff.
CULTURAL COMPETENCE

I: GENERAL POPULATION

A. Summarize the county’s general population by race, ethnicity, age, and gender. The summary may be a narrative or as a display of data (other social/cultural groups may be addressed as data is available and collected locally).

Monterey County, one of the largest counties in the state, encompasses 3,322 square miles along the coastal and valley regions of Central California. The County is ethnically diverse, comprised of 56.5% Hispanic/Latino, 31.9% White, 6.0% Asian and 2.6% African American. Pacific Islanders represent 0.5%, and American Indian and Alaskan Natives, 0.3%. Multi-race or Other is represented at 2.2%. The population is concentrated in urban areas, yet also is spread across the County in small towns and farm-labor camps, which contributes to the challenges of effective service delivery. In 2014, the total population of Monterey County was 424,927. Females comprised 48.7% of the population, and males comprised 51.3%. See Tables below.

The 2010-2014 American Community Survey five-year estimate, families made up 72.2% of all Monterey County households at the time. The average household size was 3.15 people, which was larger than the U.S. average of 2.58 people per household. Monterey County’s population has increased 2.4% from 2010 to 2014 to 9,870 residents. Between 2014 and 2015, the population increased by an additional 600 residents. The jurisdiction with the greatest percentage growth from 2014 to 2015 was Sand City, with a growth rate of 5.8%, followed by Marina, with 3.2%, and King City, with 1.8%. The most significant percentage decrease in population was in Soledad, at -1.7%. Population percentages remained the same in both Carmel-by-the-Sea and Pacific Grove.

Table 3: Monterey County Gender and Ethnicity Demographic, 2014 Estimates

<table>
<thead>
<tr>
<th>Monterey County 2014 Demographic Estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
</tr>
<tr>
<td>White/Caucasian</td>
</tr>
<tr>
<td>Hispanic/Latino (any race)</td>
</tr>
<tr>
<td>African American/ Black</td>
</tr>
<tr>
<td>Asian</td>
</tr>
<tr>
<td>Native Hawaiian, Pacific Islander</td>
</tr>
<tr>
<td>American Indian or Alaskan</td>
</tr>
<tr>
<td>Multi-Race</td>
</tr>
<tr>
<td>Total Population</td>
</tr>
</tbody>
</table>
Source: Data retrieved from the 2010-2014 American Community Survey 5 Year Estimates. Located at: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF

Table 4: Monterey County Age Distribution, 2014 Estimates

<table>
<thead>
<tr>
<th>Monterey County Total Population by Age, 2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age Group</strong></td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Youth Total Population (0-17)</td>
</tr>
<tr>
<td>Adult Total Population (18+)</td>
</tr>
<tr>
<td>Total Population</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Population Estimates for Youth by Age</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age Group</strong></td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>0-5</td>
</tr>
<tr>
<td>6-10</td>
</tr>
<tr>
<td>11-13</td>
</tr>
<tr>
<td>14-17</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Population Estimates for Adults (18+) 2010-2014 (N=424,927)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age 18+</strong></td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>18 years and over</td>
</tr>
<tr>
<td>21 and over</td>
</tr>
<tr>
<td>62 years and over</td>
</tr>
<tr>
<td>65 years and over</td>
</tr>
</tbody>
</table>


Chart 1 below shows that Monterey County youth were over 75% of Hispanic/Latino descent, 17% White, 4% Multi-Race, 3% Asian/Pacific Islander, 1% African-American and less than 1% Native American.
A variety of languages bring cultural enrichment and diversity to communities. Residents who speak languages other than English tend to require an additional level of public health-related services, including adapted outreach, prevention education, and specialized service delivery.

According to the 2014 American Community Survey, English is the language most commonly spoken at home in Monterey County (47.2%), followed by Spanish (46.2%). Recently, Monterey county has experienced a growth in the indigenous dialects of Mixteco and Triqui. BHB must be prepared to provide the same level of service to these populations. Thus, BHB is focused on hiring more language-specific bilingual therapists and clinicians, working with interpreters, and providing telemedicine to help expand language capacity and narrow service gaps. The table below outlines the range of languages spoken in homes of Monterey County residents.

### Table 5: Monterey County Language Spoken at Home, 2014 Estimates

<table>
<thead>
<tr>
<th>Language spoken at home</th>
<th>Population (n)</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>184,690</td>
<td>47.2</td>
</tr>
<tr>
<td>Spanish</td>
<td>180,775</td>
<td>46.2</td>
</tr>
<tr>
<td>Asian &amp; Pacific Islander Languages</td>
<td>15,345</td>
<td>3.9</td>
</tr>
<tr>
<td>Indo-European Languages</td>
<td>8,021</td>
<td>2.0</td>
</tr>
<tr>
<td>Other</td>
<td>2,830</td>
<td>0.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>392,915</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

*Source: US Census Bureau, American Community Survey, 2010-2014.*
II: MEDI-CAL POPULATION SERVICE NEEDS (USE CURRENT CAEQRO DATA IF AVAILABLE)

A. Summarize Medi-Cal population and client utilization data by race, ethnicity, age, gender and language as published in the most recent CAEQRO reports. Additional demographic categories, social/cultural groups and languages may be addressed as data is available and collected locally.

BHB EQRO 16-17 report shows the pattern of service for Medi-Cal beneficiaries, shown in Table 6. We can see that in 2015 there were 114,382 monthly average unduplicated Medi-Cal enrollees and 5,610 unduplicated annual count of beneficiaries served. Hispanic/Latinos had the highest percentage enrolled and served, 78.4% and 60%, respectively. Whites were the second highest enrolled and served at 8.7% and 21% respectively; the “Other” category was the third highest served and enrolled at 8.28% and 11.9% respectively; Asian/Pacific Islanders were enrolled 3.13% and served 2.90%; African-American were enrolled at 1.38% and served at 3.79% and Native Americans were enrolled at .09% and served at .17%.

In the table, we can also compare the percentage of the Medi-Cal enrollees and beneficiaries served by racial/ethnic groups and determine that in 2015 BHB overserved Whites by 12.3%, underserved Hispanics by 18.4%, overserved African Americans by 2.41%, underserved Asian Pacific Islanders by 0.23%, overserved Native Americans by 0.17 and overserved the “Other” category by 3.62%.

Table 6: Medi-Cal Eligible Enrollees vs. Beneficiaries Served

<table>
<thead>
<tr>
<th>Monterey MHP Medi-Cal Enrollees and Beneficiaries Served in CY15 by Race/Ethnicity</th>
<th>Average Monthly Unduplicated Medi-Cal Enrollees*</th>
<th>% Enrolled</th>
<th>Unduplicated Annual Count of Beneficiaries Served</th>
<th>% Served</th>
<th>Gap Calculator</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>12,567</td>
<td>8.7%</td>
<td>1,183</td>
<td>21%</td>
<td>+12.3%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>113,208</td>
<td>78.4%</td>
<td>3,367</td>
<td>60%</td>
<td>-18.4%</td>
</tr>
<tr>
<td>African-American</td>
<td>1,995</td>
<td>1.38%</td>
<td>213</td>
<td>3.79%</td>
<td>+2.41%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>4,521</td>
<td>3.13%</td>
<td>163</td>
<td>2.90%</td>
<td>-0.23%</td>
</tr>
<tr>
<td>Native American</td>
<td>133</td>
<td>.09%</td>
<td>15</td>
<td>.26%</td>
<td>+.17%</td>
</tr>
<tr>
<td>Other</td>
<td>11,958</td>
<td>8.28%</td>
<td>669</td>
<td>11.9%</td>
<td>+3.62</td>
</tr>
<tr>
<td>Total</td>
<td>144,382</td>
<td>5,610</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Forty seven percent of Monterey County residents speak English at home, while 46% speak Spanish and 7% speak another language. Of the 11,960 individuals served by BHB in FY16-17, 80% identified English as their preferred language, 17% identified Spanish and 3% identified Other language. In chart 2, we can see the difference in the percent of clients served and percent of service value across English, Spanish and Other. Overall English speaking clients have a higher percentage of service value compared to the number of clients that speak Spanish or Other language.

**Chart 2: Clients Served by Language and Age Group, FY 16-17**

![Chart 2: Clients Served by Language and Age Group, FY 16-17](image)

*Monterey County Behavioral Health, Avatar Data FY 2016-17.*

When we look at BHB’s Medi-Cal population preferred language, 54% of the clients preferred Spanish, compared to 44% English.

**Chart 3: Preferred Language of Medi-Cal Population**
Although the majority of Medi-Cal clients are Spanish speaking, when we looked closer at language of clients served compared to Medi-Cal population in FY16-17, we saw that more than 40% of the time English speaking Medi-Cal clients were being served compared to over 10% of the Spanish speaking Medi-Cal clients (see Chart 4 below).

**Chart 4: Clients Served by Language and Medi-Cal Population, FY 16-17**

In addition, the percentage of service value to the Medi-Cal population is lower compared to the percentage of Medi-Cal beneficiaries across ethnic groups, as seen in Chart 5.

**Chart 5: % of Service Value to Clients, % of Clients and % of Medi-Cal Population Served by Ethnicity, FY 16-17**
Looking at the Medi-Cal population across the county regions, as shown in Chart 6, we can see that percentage of Medi-Cal clients sum of services are lower in all parts of the county, except for those living in the Coastal Region.

**Chart 6: Clients Served by Region, FY 16-17**

On average, BHB has had higher approved claims per Medi-Cal beneficiary over time compared to the state and other medium counties. However, BHB’s Medi-Cal penetration rates are lower compared to the state and other medium counties.
B. Provide an analysis of the disparities as identified above.

Despite our best efforts, the BHB is currently only serving 50% of the Latinos in Monterey County. Since 2009 the percentage of Latinos served by BHB has stayed between 53%-56% leaving a significant gap in service. BHB’s EQRO 16-17 report shows the pattern of service for Medi-Cal
beneficiaries, from this report, we can determine Latinos are being underserved by 18.4% (Table 6) compared to Whites overserved by 12.3%. The inequitable distribution of services among Medi-Cal beneficiaries is more apparent when we see that over 78.4% of the Medi-Cal enrolled are Hispanic/Latino compared to 8.7 of Whites. From the data above, we can also determine that Spanish-speaking Medi-Cal beneficiaries experience lower service delivery, even though they make up the majority of the Medi-Cal beneficiaries (Charts 4 and 5). In addition, Medi-Cal beneficiaries that are White and live in the Coastal region, receive high service value compared to non-Whites and those living in the other regions of the county (Chart 6 and 7). This would indicate that non-Whites who reside in high poverty areas may face additional barriers to access BHB services in Monterey County.

Our data seem to indicate that Spanish-speaking Medi-Cal beneficiary Latinos experience high rates of disparities in receiving BHB services. To address this gap, BHB has set the goal of increasing services to Latinos by 7% in 3 years. BHB can achieve this goal by increasing targeted strategies efforts in community engagement efforts, increasing bilingual staff, and increase and expand outreach efforts in Salinas and southern region of Monterey County, where a large majority of the Latino population reside.

Robust community-engagement opportunities will help ensure the voices of those most affected are at the table as partners, working on realistic solutions that reduce barriers to service and stigmas around care. BHB is committed to developing strategies that will help close the gap and ensure potential bilingual clinicians are hired into the workforce. These intentional strategies will serve a dual purpose: 1) provide service and increase access to Non-English speakers; and 2) increase retention of communities that speak monolingual languages and therefore support efforts in treatment and services among those communities. As mentioned above, the South County region has a higher need of service access compared to the other regions. BHB is aware of this need, and has focused on improving access in that area by increasing program awareness efforts and offering additional services to those locations.

Targeted strategies to increase the effectiveness of mental and BHB services overall aim are to: 1) make the mental-health system easier to access; 2) provide a continuum of care, and 3) reduce the stigma that deters people from seeking assistance.

Efforts include:

- Prevention and early intervention programs
- Technology upgrades
- Integrated system of care
- Facilities expansion
- Increased housing opportunities
- Additional education and training for staff and consumers
- Additional cultural competency trainings to existing staff
There may be additional strategies identified through our innovative projects to increase BHB service and access to Spanish-speaking Latinos.

III: 200% OF POVERTY (MINUS MEDI-CAL) POPULATION AND SERVICE NEEDS.
A. Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, and gender. Additional demographic categories, social/cultural groups and languages may be addressed as data is available and collected locally.

Currently our system does not distinguish between service beneficiaries who fall under the 200% Federal Poverty Level (FPL), however in the future we plan to analyze the data more closely to obtain that number. In 2016, Monterey County’s total population was 406,132 out of which 41.96% (170,407) were living under the 200% FPL. This is almost 6.0% higher than the state average of 36.37% and 7.0% higher than the national average of 34.54%.


The charts below indicate the population of uninsured by race and ethnicity in Monterey County.

![Monterey County Percent of Uninsured, by Race Alone](https://www.svmh.com/documents/Meeting-Agendas/july-2016-community-advocacy-committee-meeting-packet.pdf)

Monterey County has a higher rate of uninsured children and adults who are Medi-Cal eligible. In 2016, the total population of Medi-Cal eligible individuals in Monterey County was 40.10% compared to the state’s average of 33.40%.

<table>
<thead>
<tr>
<th>Table 7: Medi-Cal Eligible and Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monterey County</td>
</tr>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td>Medi-Cal</td>
</tr>
<tr>
<td>Uninsured</td>
</tr>
</tbody>
</table>


In year FY 15-16, 68% percent of our service beneficiaries, in all age groups, reported Medi-Cal as their primary source of insurance. That same year BHB served 11,960 clients, 53% of them were Hispanic/Latinos, 22% were White, 4% were African American, 3% were Asian/Pacific Islander, and 17% reported as other. The majority of BHB clients speak English (80%) and there are an equal percentage of male and females being served.

**B. Provide an analysis of disparities as identified in the above summary.**

From the data presented above we can determine that almost 50% of our population are living at or below the FPL, and that although the number of Medi-Cal eligible individuals is high there is still a service gap, primarily within the Hispanic/Latino community. Further, evidence of the same finding was presented in the EQRO FY16-17 report. Therefore, BHB is committed to closing the gap and providing services to the Hispanic/Latino community, thus setting the goal of increasing services for the population by 7% over the next 3 years.
IV. MHSA COMMUNITY SERVICES AND SUPPORTS (CSS) POPULATION ASSESSMENT AND SERVICE NEEDS.

In FY 16-17 MHSA served a total of 11838 clients through-out Monterey County. Fifty three percent of those clients were Hispanic/Latino, 22% White/Caucasian, 17% identified as “Other”, 4% Black/African American, 3% Asian/Pacific Islander and data was not collected for Native American. Half of those served were men and the other half women (see Chart 10).

Table 8: MHSA Monterey County Behavioral Health Clients Served FY 16-17

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th># of Clients</th>
<th>% of Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black/African American</td>
<td>478</td>
<td>4</td>
</tr>
<tr>
<td>Asian/ Pacific Islander</td>
<td>358</td>
<td>3</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>6338</td>
<td>53</td>
</tr>
<tr>
<td>Native American</td>
<td>No data collected</td>
<td>No data collected</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>2631</td>
<td>22</td>
</tr>
<tr>
<td>Other than specified</td>
<td>2033</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td>11838</td>
<td>100</td>
</tr>
</tbody>
</table>


Chart 11: Clients Served by Gender, FY16-17

Source: Monterey County Behavioral Health, 3 Year FY18-20 Expenditure Plan.
The chart below compares the percentage of service value to the percentage of clients served across racial/ethnic groups. Overall, MHSA provided more service value to Whites (31%) relative to percentage of clients served (22%). When we take a closer look at the total number of services received in a year by Hispanic/Latino and non-Hispanic/Latino, fewer Hispanic/Latinos coming are going to more than 51 visits compared to non-Hispanic/Latinos (chart 11).

### Chart 12: Breakdown of Clients Served by Ethnicity, FY16/17

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>% of Clients Served</th>
<th>% of Service Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic/Latino</td>
<td>49</td>
<td>53</td>
</tr>
<tr>
<td>White</td>
<td>31</td>
<td>22</td>
</tr>
<tr>
<td>African American</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>17</td>
</tr>
</tbody>
</table>

*Monterey County Behavioral Health, Avatar Data FY 2016-17.*

### Chart 13: Clients Served Grouped by Number of Services Received During the Year, FY16/17
The chart below shows the percentage of Hispanic/Latino and Non-Hispanic/Latinos served over an eight-year period. Hispanic/Latinos consistently are served between 56-53%, while Non-Hispanics are served between 47-44%.
Specifically looking at CSS population assessment and service needs, there is a mix of FSP and non-FSP programs for Children and Youth, Transitional Age Youth, Adult and Older Populations. FSP programs were 30% of the overall FSP budget in FY16-17 (total budget of 29,626,423). FSP programs include Family Stability FSP, Dual Diagnoses FSP, Juvenile Justice, Transitional Age Youth, Adult SMI, and Older Adults. The Non-FSP programs included Access Regional Services, Early Childhood Intervention, Transitional Age Youth, Support Services to SMI, Dual Diagnosis, and Family Stability. Source: Mental Health Services Act FY 18-20, Three Year Program and Expenditure Plan. Located at [http://www.co.monterey.ca.us/home/showdocument?id=46412](http://www.co.monterey.ca.us/home/showdocument?id=46412)

**Provide an analysis of disparities as identified in the above summary.**

MHSA has increased the overall service penetration rates for Hispanics/Latinos in Monterey County. However, improvements in this area are still warranted. One barrier to providing services, has been the limited number of bilingual and/or bicultural workforce pool in the Monterey County area. BHB has actively worked to find a solution to this and has effectively collaborated with Santa Cruz and San Benito counties and CSUMB to launch the Master’s level Social Work Program. This will increase the likelihood of a locally educated workforce ready to support BHB efforts with not only their acquired skillset but potentially fulfill their diversity need.

In addition to this achievement, BHB’s MSHA Plan will continue to support work with community-based health partners, such as Clínica de Salud del Valle de Salinas (CSVs), integrated health clinics of Monterey County and Natividad Hospital to develop strategies that may lead to an increase in the number of access points for eligible individuals - particularly those who live in the unserved and underserved rural areas of Monterey County.
A. Which PEI priority population(s) did the county identify in their PEI plan?

In October 2015, Mental Health Services Oversight and Accountability Commission (MHSOAC) released revised PEI regulations requiring specific program categories and strategies to be employed. In compliance with these regulations BHB PEI’s programs are organized into six categories (prevention, early intervention, access and linkage to treatment, suicide prevention, stigma and discrimination reduction and outreach for increasing recognition of early signs of mental illness) and three strategies (access and linkage to treatment, improve timely access to services for underserved populations, and non-stigmatizing and non-discriminatory practices. All BHB programs fall under one of the six categories, however a singular program may implement more than one strategy to meet its program objectives.

BHB’s collective efforts with the Mental Health Commission and QI data have helped identify Spanish-speaking Medi-Cal beneficiary Latinos and those communities living in South County with the lowest percentages of receiving BHB services, as stated above, BHB has set the goal of increasing services to Latinos by 7% by 2020.

B. Describe the process and rationale used by the county in selecting their PEI priority population(s) (e.g., assessment tools or method utilized)

The collaborative approach BHB has taken to help identify MHSA funded populations, including PEI populations, is important to note. BHB looked to our internal QI data reports, in addition to seeking guidance and support from BHB’s Mental Health Commission (the Commission) to evaluate and enhance local MHSA program planning with a community-driven perspective.

The evaluation process began with the appointment of an Evaluation Ad Hoc Subcommittee from the Commission, to work with BHB staff and give the Commission’s input for the 2017 MHSA Plan Annual Update. This input also forms the foundation for this MHSA 3-Year Program and Expenditure Plan covering FY 17-18 through FY 19-20. Between September 2016 and June 2017, ten (10) meetings were convened, typically immediately preceding the regular Mental Health Commission meeting. Over the course of the ten months, the Commission considered the following items:

1. A “Proposal: How We Will Describe Programs for the Upcoming FY18-20 MHSA 3-Year Program & Expenditure Plan.” The Commission members shared their suggestions for what kinds of information and what formats would be useful in the upcoming MHSA Plan document;

2. A proposed structure that could be used to rank programs according to criteria such as addressing disparities, reaching the underserved and providing equitable services. The Commission members also discussed ways to go out into the community and engage
in a dialogue about unmet needs;
3. A document showing the “continuum” of MHSA funded services;
4. A revised draft of the proposed MHSA Program Review/Evaluation structure (See Appendix I for “MHSA Program Review to Support the 3-Year Plan Development” and corresponding “MHSA Program Evaluation Structure”). The Commission provided feedback on the proposed structure and how it could be presented to the general public;
5. Preliminary data from the Underserved Communities (by Zip Code) Survey, conducted by the Center for Community Advocacy, the Health Department’s enLACE program staff, and the PEI Coordinator, in the zip code areas where there are high concentrations of Latino residents who are not yet engaged in the community mental health system.

At the end of this ten month process and several discussions in-between, it was concluded that a realistic goal would be to increase services to Latinos by 7% by 2020, therefore services to the South County region as well as in Salinas, where the highest concentration of Latinos resides will be prioritized.
Rationale: “Striking disparities in mental health care are found for racial and ethnic populations. Racial and ethnic populations have less access to and availability of mental health services; these communities are less likely to receive needed mental health services. And, when they get treatment, they often receive a poorer quality of mental health care. Although they have similar mental health needs as other populations, they continue to experience significant disparities. Should these disparities go unchecked, they will continue to grow, and their needs will continue to be unmet. . .” (U.S. Department of Health and Human Services, Surgeon General Report, 2001).

I. IDENTIFIED UNSERVED/UNDER SERVED TARGET POPULATIONS (WITH DISPARITIES)

Progress Toward Reducing Disparities

BHB has increased efforts to reduce barriers to mental health services to target populations. The following discussion outlines how disparities are being addressed for each underserved and unserved population.

A. Medi-Cal population

According our Data Driven Decision (D3) FY 2016-17 report, sixty-eight percent of clients currently served by BHB utilize Medi-Cal as their primary source of insurance. BHB breaks down the Medi-Cal population by ethnicity and region, as part of aligning services with the needs of this population. Medi-Cal beneficiaries eligible for mental health services are primarily Hispanic, located predominately in the Salinas Valley region of Monterey County. Forty-nine percent of the Medi-Cal population resides in the Salinas Valley, 17% in the coastal region, 12% in the North County region, 18% in the South County region, and 4% in other areas. Seventy-five percent of the Medi-Cal population is Hispanic/Latino, 11% is White, 2% is...
African American, 4% is Asian/Pacific Islander, and 8% identify as other. Monterey County Health Department, along with community-based partner organizations, is engaged in Medi-Cal outreach and enrollment efforts to support the expansion of healthcare coverage for individuals eligible for Medi-Cal.

B. Community Services Support (CSS) population: Full-Service Partnership Population

The populations chosen to be included in the CSS Plan are Children & Youth, ages 0-16 (C&Y), Transitional-Age Youth, ages 16-25 (TAY), Adults, ages 26-59, and Older Adults, ages 60 and above. Monterey County has service programs targeted at each of these age groups, as detailed below. The Children & Youth and Adult programs also include an Access to Treatment Component. CSS programs are culturally competency, community based and recovery “wraparound” programs serving individuals affected by moderate to severe mental illness and their families. These “wraparound” services include treatment, case management, peer support, transportation, housing, crisis intervention, family education, vocational training employment services in addition to socialization and recreational activities based on the individuals needs to obtain successful treatment outcomes.

C. Workforce, Education, and Training (WET) population: Targets to grow a multicultural workforce

Monterey County Workforce Education & Training (WET) funds, under MHSA, support statewide, regional and local strategies to develop the existing and future mental health workforce. The WET plan promotes the employment of consumers and family members. This includes providing job training, educational support services, job coaching and more. The populations of focus in this County are culturally specific Adults, and Transitional-Age Youth over 18 years, as outlined below. The WET plan serves individuals who have lived with serious mental illness and are interested in working in the public health system. Currently, BHB is not receiving WET funding, however a full-time training manager has been hired to maintain workforce and retention training efforts to our staff.

D. Prevention and Early Intervention (PEI) priority populations: These populations are county identified from the six PEI priority populations

The new PEI focus is to prevent mental illness from becoming serve and disability for all PEI programs. PEI will focus on direct and indirect programs that can support this overarching goal. Direct programs will focus early intervention and prevention strategies that have outcomes for individuals with risk or onset of mental illness. These program will include components of improved timely access to services for underserved populations, outreach to families, employers, primary care health care providers, and other to recognize the early signs of potentially severe and debilitating mental illness, and access and linkage to medically necessary care provided by county mental health programs for children with severe mental illness and adults and seniors with severe mental illness as early in the onset of these conditions as possible.
Unserved or underserved cultural populations including individuals who are not likely to seek services because of ethnicity, race, sexual orientation or stigma. Trauma-exposed individuals include those who have experienced prolonged trauma, grief or isolation. Children in stressed families include children whose parents have been diagnosed with a mental illness, a serious health condition, have substance abuse issues, or have been incarcerated. It also includes children who have witnessed domestic violence or have experienced child neglect or abuse. Children and Youth at risk of juvenile justice involvement include those who have had the first point of contact with the juvenile justice system.

E. List identified target populations, with disparities, within each of the above selected populations (Medi-Cal, CSS, WET, and PEI priority populations).

Medi-Cal Population:
The Medi-Cal Approved Claims Data for Calendar Year 2015 (CY15), referenced in Criterion 2, Section II A, reports that the Medi-Cal population with the biggest disparity in service is the Hispanic/Latino population, which totals 113,208 eligible Medi-Cal enrollees. The figure below demonstrates the low penetration rate when compared to medium-sized counties and statewide averages. The penetration rate for Hispanics/Latinos is slightly higher in CY 15 compared to other medium size counties, an improvement from past years when compared to other ethnic/racial groups. This may reflect BHB’s active engagement in implementing strategies to increase service provision to Hispanics/Latinos.

Chart 15: Hispanic/Latino Penetration Rates, FY15

Source: Monterey County MHP CalEQRO Report, Fiscal Year 2016-2017
Medium refers to Bay Area Regional county size
Community Services & Support (CSS): Full-Service Partnership

The following Full Service Partnerships (FSP) for children and families are designed to prevent out-of-home placement of children and youth whose emotional, social, and/or behavioral problems that create a substantial risk of placement in publicly funded care, such as foster homes, group homes, correctional institutions, or psychiatric facilities. These FSP’s provide a range of options for families, including a short- term crisis stabilization model, an integrated model involving Family and Children’s Services and MCBH and a specialized model focusing on Adoption Preservation. Research has shown that adoption disruptions can be prevented through the utilization of a continuum of adoption related services that include case management, therapeutic care, and skills acquisition training. With a focus on educating and empowering families to meet the needs of their children, even in high intensity situations, these programs can allow families to remain together.

Resources connected to Full-Service Partnerships (FSPs) were used specifically for these populations to more fully assist in addressing service disparities. More information on strategies developed to address these disparities can be found below, in Criterion 3, Section III A.

Workforce Education & Training (WET):
No additional state WET funds were available for FY 2014-2015 and FY 2016-2017. Workforce Education and Training activities are still being funded through other BHB sources; however, funds are still not sufficient to significantly close gaps in identified areas of need.

Some of the identified areas of need include:
- Staff development and training support;
- Consumer and family member training;
- Workforce development specialist to provide vocational support of consumers and family members employed in the public mental health system;
- California State University Monterey Bay Master of Social Work (MSW) Program;
- Stipends and incentives to increase number of local applicants; and
- Law Enforcement/First Responder Crisis Intervention Training (CIT).

Prevention & Early Intervention (PEI):
The following are PEI identified strategies in the PEI Plan:
- Access and linkage to treatment
- Improve timely access to services for underserved populations
- Non-stigmatizing and non-discriminatory practices

PEI programs are organized into six categories of prevention, early intervention, access and linkage to treatment, suicide prevention, stigma and discrimination reduction and outreach for increasing recognition of early signs of mental illness.
F. PEI priority population(s) with disparities, describe the process and rationale the county used to identify and target the population(s) (with disparities).

It has been a priority to have community input for BHB programs to help address gaps and needs for all components of the Mental Health Service Act, including PEI. BHB has collaborated with several communities, stakeholders, and other staff to support the gathering of information, extensive discussion and generated reports and/or recommendations in identifying communities with disparities. This process has proven to identify underserved communities in a transparent and meaningful way.

Community members consistently identified nontraditional settings such as homes, schools, neighborhoods, faith-based venues and community organizations as means of effective outreach to Latinos, African Americans, agricultural farm workers, LGBTQ, older adults, stigmatized, and other vulnerable populations.

BHB will continue to use this approach to support programs that detect early mental health illness through prevention, early intervention, access and linkage to treatment, while also promoting support to those that are experience mental health illness by “wrap around services” that will increase their likelihood of success to recovery. All programs will conduct outreach efforts designed to reach the underserved and unserved cultural populations and to reduce mental health disparities in Monterey County.

II. IDENTIFIED DISPARITIES (WITHIN THE TARGET POPULATIONS)

A. List disparities from the above-identified populations (Medi-Cal, CSS, WET and PEI’s priority/targeted group).

Medi-Cal:

One of the key identified disparate areas among the target groups is the ratio of Hispanic/Latino Medi-Cal beneficiaries (113,208) to the actual number of Hispanic/Latino beneficiaries being served by BHB (3,367). Whites represent a smaller number of Medi-Cal beneficiaries (12,567), and have a higher rate of service (1,183). BHB is focused on reducing this disparity through programs that specifically reach out to the Hispanic/Latino population, along with the hiring and retention of qualified bilingual staff, and the provision of language-appropriate and culturally relevant services.

Community Services and Supports (CSS):

Disparities found during the CSS Planning Process are being addressed in the programs listed below. They include:

Access. The need to increase access to services, reduce long wait lists for appointments and expand capacity is especially true for those who are unserved or underserved. Newly established programs and partnerships with local, community-based organizations as well as the expansion of BHB
services into disadvantaged communities is helping to improve access, for example, over the last two years we have increased services to the community by 90%. BHB will continue to develop and implement new and innovative strategies to help narrow the access gap even more.

**Integrated care.** The need for more integrated services to help people with co-occurring mental health and substance abuse disorders includes the need for better integration of mental health and physical health services, especially to serve the needs of older adults since there is no older-adults system of care. One strategy proven successful has been the integration of BHB services into the county clinic system. This approach has made a dent in the barriers impeding access to services by making services more readily available to those who need them the most.

**Wellness and recovery.** Among children and transition-age youth is a need for a safe place for severely emotionally disturbed youth or justice involvement at risk youth, and a need for a place to develop support groups, youth mentors, meaningful activities, life-skills training, and employment assistance. Among adults and older adults are issues of social isolation, lack of life meaning, need for support, deficits in basic-life skills, and needs for employment assistance. Wellness centers and community-based organizations could help address these needs by providing peer and family support, life-skills training, mentoring, jobs/health services, and housing referral.

**Homelessness.** The need for expanded capacity to serve the homeless, is particularly acute among those who are dealing with a co-occurring mental health and substance-abuse disorders. This includes wrap-around services and supportive housing services for transition-age youth, adults, and older adults.

**Criminal justice.** The need to provide better and more integrated mental health services for persons in the criminal justice system includes collaboration to establish mental-health courts for clients who have criminal charges.

**Workforce, Education & Training (WET):**

The WET plan currently has no state funding. Disparities within this component include the comparability of workforce, by race and ethnicity, to the target population receiving public mental health services. Although some progress has been made, BHB sees this as an area in need of continued development. Cultural representation within BHB is another area where disparities are apparent. Available positions within BHB are hard to fill due to the skill level required. Additionally, Hispanics/Latinos and African Americans are underrepresented in the local mental health workforce field.

Despite the lack of funding for workforce education and training, BHB still manages to provide workshops and training through other funding sources. The list below provides a description of trainings provided in 2016-17.

**Table 9: Monterey County Behavioral Health WET 2016-17**
<table>
<thead>
<tr>
<th>Topic</th>
<th>Date</th>
<th>Trainer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title 42 Training</td>
<td>06/28/16</td>
<td>Linda Garrett</td>
</tr>
<tr>
<td>Unified Protocol</td>
<td>07/08/16</td>
<td>Shannon Sauer Zavala</td>
</tr>
<tr>
<td>Non-Violent Crisis Intx (CPI)</td>
<td>07/19/16</td>
<td>Melanie Rhodes</td>
</tr>
<tr>
<td>5150 Practical Situations</td>
<td>08/30/16</td>
<td>Melanie Rhodes</td>
</tr>
<tr>
<td>SUD TX &amp; Management</td>
<td>09/07/16</td>
<td>Mark Stanford</td>
</tr>
<tr>
<td>Non Violent Crisis Intx (CPI)</td>
<td>09/15/16</td>
<td>Melanie Rhodes</td>
</tr>
<tr>
<td>5150- Legal requirements</td>
<td>09/28/16</td>
<td>Dave Vandenberg</td>
</tr>
<tr>
<td>Wellness Conference</td>
<td>10/18/16</td>
<td>Jill Walker</td>
</tr>
<tr>
<td>Non-Violent Crisis Intx (CPI)</td>
<td>11/03/16</td>
<td>Melanie Rhodes</td>
</tr>
<tr>
<td>LGBTQ Data Collection</td>
<td>11/09/16</td>
<td>Jill Walker</td>
</tr>
<tr>
<td>LGBTQ Data Collection</td>
<td>11/10/16</td>
<td>Jill Walker</td>
</tr>
<tr>
<td>Providing Equal Access for Transgendered Population</td>
<td>01/11/17</td>
<td>Willy Wilkinson &amp; Dr. Jennifer Hastings</td>
</tr>
<tr>
<td>Getting Going with Groups</td>
<td>01/31/17</td>
<td>Kristin Dempsey</td>
</tr>
<tr>
<td>Non-Violent Crisis Intx (CPI)</td>
<td>03/28/17</td>
<td>Melanie Rhodes, Amanda Briseno &amp; Merideth Canham Nelson</td>
</tr>
<tr>
<td>Bright Minds</td>
<td>03/29/17</td>
<td>Kristin Dempsey</td>
</tr>
<tr>
<td>Law &amp; Ethics Non-Clinical</td>
<td>04/13/17</td>
<td>Linda Garrett</td>
</tr>
<tr>
<td>Law &amp; Ethics Clinical</td>
<td>04/13/17</td>
<td>Linda Garrett</td>
</tr>
<tr>
<td>Law &amp; Ethics MA</td>
<td>04/14/17</td>
<td>Linda Garrett</td>
</tr>
<tr>
<td>ART</td>
<td>04/18/17</td>
<td>Elizabeth Tyler</td>
</tr>
<tr>
<td>Motivational Interviewing</td>
<td>04/25-04/26 2017</td>
<td>Kristin Dempsey</td>
</tr>
<tr>
<td>5150 Practical Situations</td>
<td>05/09/17</td>
<td>Melanie Rhodes</td>
</tr>
<tr>
<td>ASAM Criteria- Content Experts</td>
<td>05/16-05/17 2017</td>
<td>Scott Boyle</td>
</tr>
<tr>
<td>Non-Violent Crisis Intx (CPI)</td>
<td>05/23/17</td>
<td>Melanie Rhodes</td>
</tr>
<tr>
<td>Motivational Interviewing</td>
<td>05/30/17</td>
<td>Kristin Dempsey</td>
</tr>
<tr>
<td>ASAM Criteria - Change Agents</td>
<td>08/22/17</td>
<td>Scott Boyle</td>
</tr>
<tr>
<td>Planning Meeting</td>
<td>09/19/17</td>
<td>Dr. Miller</td>
</tr>
<tr>
<td>Motivational Interviewing</td>
<td>09/19/17</td>
<td>Kristin Dempsey</td>
</tr>
<tr>
<td>Productivity</td>
<td>09/26/17</td>
<td>Jill Walker</td>
</tr>
<tr>
<td>Wellness &amp; Recovery Conference</td>
<td>10/03/17</td>
<td>Jill Walker</td>
</tr>
<tr>
<td>Motivational Interviewing</td>
<td>10/11/17</td>
<td>Dempsey</td>
</tr>
<tr>
<td>5150 Legal Requirements</td>
<td>10/18/17</td>
<td>Jill Walker</td>
</tr>
<tr>
<td>Using data to Support Improvement</td>
<td>10/20/17</td>
<td>Dr. Miller</td>
</tr>
<tr>
<td>Assessment</td>
<td>10/24/17</td>
<td>Jill Walker</td>
</tr>
<tr>
<td>Treatment Planning</td>
<td>11/07/17</td>
<td>Jill Walker</td>
</tr>
<tr>
<td>New Supervisors</td>
<td>11/13/17</td>
<td>Stern</td>
</tr>
</tbody>
</table>
Prevention & Early Intervention (PEI):
Per new State regulations, BHB PEI’s programs are organized into six categories (prevention, early intervention, access and linkage to treatment, suicide prevention, stigma and discrimination reduction and outreach for increasing recognition of early signs of mental illness) and three strategies (access and linkage to treatment, improve timely access to services for underserved populations, and non-stigmatizing and non-discriminatory practices. All BHB programs fall under one of the six categories, however a singular program may implement more than one strategy to meet its program objectives. Programs that fall under PEI include:

Access:
BHB continues to work in access to programs and services. The charts below demonstrate the breakdown of clients served by region and ethnicity. They clearly illustrate which areas still require attention and intentional outreach efforts to ensure equitable access to services.

**Chart 16: Percent of Clients Served by Region of Residence**

A clear disparity surfaces in the amount of culturally relevant and linguistically appropriate services available to BHB clients. In the juvenile justice system, young males have higher rates of incarceration and tend to be Hispanic/Latino, as illustrated in the graphs below.

**Chart 17: Juveniles Involved with the Justice System by Gender, FY 15**

Juveniles Involved with the Justice System by Gender

![Pie chart showing 68% Males and 32% Females involved in the justice system](image)

*Monterey County Behavioral Health, Avatar Data FY 2016-17*
III. IDENTIFIED STRATEGIES/OBJECTIVES/ACTIONS/TIMELINES

A. List the strategies identified in CSS, WET, and PEI plans, for reducing the disparities identified.

MHSA FY16-17 identified strategies, programs and actions to aid in the reduction of the disparities for CCS, PEI, and WET clients. Program details are below:

CCS Strategies/Objectives/Actions:

**Children and Youth**

There were 3,274 clients ages 15 and under that were served in FY 15-16. The majority were male (57%) and racially/ethnically Hispanic/Latino (65%), Other (18%), White (11%), African American (4%), and Asian/Pacific Islander (2%). Seventy one percent preferred to speak English.

**Adoption Preservation (Kinship Center) (FSP)** Services include parent pre- and post-adoption training and education, as well as mental health therapy and case management services for children and their adoptive family.
Early Childhood Secure Families (0-5 yrs.): Services include, counseling services for children in childcare and Head Start programs. This is a collaborative effort with First 5 Monterey County, providing developmental screens, assessment, dyadic therapy and case management. Mental health consultation is provided via Family Resource Centers, Head Start Centers, and Salinas Adult School. During FY 15-16, services will be expanded to South County.

Family Preservation: The Family Preservation and Home Partners teams are components of an intensive, short-term, in-home crisis intervention and family education program. This is designed to prevent the out-of-home placement of children whose emotional, social, and/or behavioral problems create a substantial risk of placement in publicly funded care, such as foster homes, group homes, correctional institutions or psychiatric facilities. This program is designed to defuse the immediate crisis, stabilize the environment, and assist families to develop more effective parenting skills and coping abilities.

Family Reunification Partnership (FSP): This program is an intensive therapy and case management services for children in the foster care system, provided by an integrated team consisting of Children’s Behavioral Health (CBH) therapists and Family and Children’s Services (FCS/DSS) social workers. The team provides services to families who are court-ordered to receive family reunification services, and who face greater-than-normal challenges in safely reuniting and creating a stable home environment that will support the mental health and emotional needs of their children.

Juvenile Justice: Mental Health Court (FSP): The “Community Action Linking Adolescents,” or “CALA” program, provides intensive mental health services & case management for youth in the juvenile justice system. It consists of a multidisciplinary team, consisting of Probation, Juvenile Court and Behavioral Health, provides supervision and support to youth and their families.

Co-Occurring Disorders “ICT” (Door to Hope) (FSP): This program is integrated treatment for youth with co-occurring mental illness and alcohol/other drug abuse. ICT is designed to prevent youth from having to be placed out of the home. Youth who meet the co-occurring criteria and are at risk of out-of-home placement are referred to this program. The team provides individual and family therapy, as well as peer mentor support. During FY 15-16, the age group being provided these services expanded, from the current 12 to 18 yrs., to include Transition-age Youth (defined by the MHSA as 16 to 25 yrs.)

Nueva Esperanza (Door to Hope): This is a recovery program for pregnant and parenting women with young children, providing integrated mental health and substance-abuse treatment in a residential setting.

Santa Lucia (Door to Hope): This is a residential treatment program for adolescent females with co-occurring disorders, providing a nine-month, intensive treatment program to at-risk adolescent females with substance abuse issues and mental health challenges. Youth are placed by the Monterey County Probation and Social Services departments.
**Transition Age Youth (TAY)**

There were 2,150 clients served in FY 15-16 between the ages of 16-25, the majority were male (52%) and racially/ethnically were Hispanic/Latino (60%), White (17%), Other (15%), African American (5%), and Asian/Pacific Islander (3%) and the majority preferred to speak English (88%). Below are programs offered to TAY clients.

**Avanza (FSP):** The Avanza program nurtures and empowers youth and young adults, ages 16 to 25, who have mental health disorders, by providing comprehensive case management, therapy, groups and opportunities for positive social interactions. The program aids with removing barriers related to mental health issues, and helps youth move forward with their goals of employment, education, independent living skills, and personal functioning. The program connects Transition-Age Youth (TAY) with community resources, jobs and educational opportunities. Psycho-education and support is also provided to family members, as they are an important part of a young adult’s support system and are critical in their success. Collaborative partners are: TAY, family members, community-based, youth-serving organizations, juvenile probation, education, and social services.

**Supportive Housing (Peacock Acres, Inc.) (FSP):** The Incarceration to Success Program (“I2S”) provides transitional housing for Severely Emotionally Disturbed (SED) male youth, who have either graduated from the Probation Department’s Youth Center, or who have been participating in Behavioral Health’s Juvenile Justice Team’s mental health treatment programs. The program offers intensive supportive services, including educational, vocational, social, and community support as well as therapeutic and psychiatric services, when needed.

**Adults**

There were 4,683 clients served in FY 15-16 between the ages of 26-59, the majority were female (52%), and ethnically comprised of Hispanic/Latino (45%), White (30%), Other (16%), African American (5%), and Asian/Pacific Islander (4%). Eighty-one percent preferred to speak English. Below are programs offered to clients in the Adults System of Care.

**McHome, Lupine Gardens & Sunflower Gardens (Interim, Inc.) (FSP)** The McHome program provides an array of services to the homeless, who are experiencing mental illness. Outreach and engagement, intensive case management and medication support are provided in collaboration with BHB staff and other local homeless services providers. Intensive supportive housing services are provided at Lupine Gardens and Sunflower Gardens.

**HIV/AIDS Community Partnership (Community Human Services)**

This program provides mental health services for persons with HIV or at high-risk of HIV infection.

**Mental Health Court (FSP):** MHSA funds have sustained the “Creating New Choices” program, which provides mental health services, case management and supportive housing to non-violent
offenders in collaboration with the Probation Department, District Attorney, Public Defender, the Court, and community-based agencies, including Interim, Inc.

Co-Occurring Integrated Care (Interim, Inc.): This dual-recovery program provides skill-building groups, recovery-oriented, community-based groups and other structured activities, which promote healthy community living and help to reduce the triggers that lead to relapse of substance use.

Workforce Support & Counseling (Central Coast Center for Independent Living “CCCIL”): This Independent Living program provides services to people with disabilities, such as information and referral, housing assistance, individual advocacy, peer support, personal assistance services, independent-living-skills training, systems advocacy, assistive technology support (devices to help people with disabilities live independently) and benefits counseling.

Nueva Esperanza (Door to Hope): This is a recovery program for pregnant and parenting women with young children, providing integrated mental health and substance-abuse treatment to women, in a residential setting.

Older Adults

There were 728 clients 60 and older served in FY15-16, the majority were female (56%), and racially/ethnically comprised of White (49%), Hispanic/Latino (27%), Other (13%), African American (6%), and Asian/Pacific Islander (5%). Eighty-two percent preferred to speak English. The following programs are offered to our older adult clients.

Integrated Care/Older Adults FSP: The program coordinates with existing multi-disciplinary teams, serving older adults with co-occurring physical and mental illness. BHB staff provide “whatever it takes” for older adults experiencing serious mental illness.

Supportive Housing (Front St. Inc.) (FSP): Drake House provides 24-hour residential care, mental-health services and case management for older adults with serious mental illness and co-morbid physical illness/other conditions.

PEI Population Strategies/Objectives/Actions:

Per new State regulations, BHB PEI’s programs are organized into six categories (prevention, early intervention, access and linkage to treatment, suicide prevention, stigma and discrimination reduction and outreach for increasing recognition of early signs of mental illness) and three strategies (access and linkage to treatment, improve timely access to services for underserved populations, and non-stigmatizing and non-discriminatory practices). All BHB programs fall under one of the six categories, however a singular program may implement more than one strategy to meet its program objectives. Programs details are below.
Unserved and Underserved Cultural Populations

McSTART (Door to Hope): This program ensures that children under 5 have access to developmental screening and appropriate referral for services, to foster positive physical, emotional and cognitive development. Therapists work with school faculty by providing mental health consultation in preschool classrooms, observations, and dialogue with school staff. By identifying problems with self-regulation, and providing low-intensity, brief therapy before elementary school, fewer children will need treatment later, and academic performance will improve.

Mental Health Screening for Children ages 5-8: This program ensures that children, ages 5 through 8, will have access to developmental screening and appropriate referral for services. This program extends the services provided by the Early Childhood program (above) to children through age 8 who need screening, assessment and preventative/early intervention services.

African American Community Partnership (The Village Project, Inc.): This program provides professional development services, thereby increasing the availability of culturally competent services for the African American community. The Partnership’s work includes cultural competency development, and systematic outreach activities. The Village Project also provides individual and family counseling, parenting groups, and other prevention services. This program is also supported by CSS funds.

Latino Community Partnership aka Promotores/Promotoras (Center for Community Advocacy and Central Coast Citizenship Project): Health promoters, aka “promotors de salud” or “promotores” are recruited to participate in the program by two community-based organizations. The promotores provide the Latino community with knowledge and skills about mental health services and access. The knowledge component focuses on health topics and behaviors that have been identified as relevant by Latino immigrants. The skills component focuses on skills necessary to carry out the outreach activities, such as communication skills, problem solving and resource collaboration.

Multilingual Parenting Services-Parent Education Partnership (Community Human Services): This is a lead agency that works in collaboration with school districts and family resource centers to provide parenting skills development in an eight to 10-week series, utilizing the Positive Parenting Program curriculum. This program increases parent awareness of mental health issues and community resources, providing culturally and linguistically appropriate parent education.

LGBTQ Outreach and Counseling (Community Human Services): This program provides mental health outreach to LGBTQ individuals. Services include client engagement, early intervention, and improvement in personal functioning through culturally competent, mental health counseling services.
School Based Counseling (Pajaro Valley Prevention and Student Assistance): This program provides funding for school-based counseling services to students not eligible for Medi-Cal reimbursable mental-health services.

Peer to Peer Counseling a.k.a. Our Friends, Our Voices Program (Interim, Inc.): This program provides adults with a structured form of mutual support in a setting of agreed confidentiality, allowing consumers a safe environment. Support groups are consumer driven with consumer leadership opportunities. Minimal guidance by a mental-health clinician as advisor is available as needed. Offered on a weekly basis in non-traditional settings, this program promotes wellness and recovery, provides emotional support, and helps prevent psychiatric decompensation.

Family Support Groups: This program provides support groups to families of individuals with mental illness, so they can be part of a stable community of persons living with similar problems and concerns. The Family Support Groups provide families a greater understanding of the signs and symptoms of mental illness. The groups are offered in English and Spanish, monthly or bi-monthly, in all three regional offices, in early evening and facilitated by a trained mental health professional. Benefits of participation in the support groups include: making connections, improving coping skills, getting motivated, and finding hope.

Adult Wellness Center/OMNI Resource Center (Interim, Inc.): The OMNI Resource Center provides outreach, prevention education, and peer support, which contribute to improvements in personal functioning through the development of social and independent living skills. Services are delivered by paid consumers and volunteer staff, with administrative oversight from a nonprofit mental health services organization.

Senior Peer Counseling & Senior Companion Programs (Alliance on Aging and Seniors Council): The senior peer counselors are individuals who volunteer their time in supporting their peers in meeting the challenges of aging, e.g. dealing with depression, grief, loss, isolation and other stressors. Senior peer counselors go through an intensive training program and are supervised by professionals. The program also serves as a link for participants to access a variety of other support groups and services in the community. Expansion has enhanced efforts to reach Latino seniors in the Salinas Valley region.

Toll-free, 24/7 Telephone Referral System 2-1-1 (United Way Monterey County): The 2-1-1 system successfully operates in other California counties and reaches approximately 65% of the population nationwide. The system provides services in more than 100 languages to residents of all age groups and races/ethnicities. Screening and referral of calls improves responsiveness of mental-health crisis services, by diverting non-mental-health information calls to more relevant agencies. The 2-1-1 in Monterey County also operates a website.

Health Promotion/Addressing Disparities: Community partners use various communication strategies, including newspapers articles, air time, radio shows, social media, digital stories, outreach events to raise awareness among high-need populations about mental health issues and mental health services available in Monterey County. They provide at least one cultural-competence training per year for all staff (county and contract providers), relevant to the languages
and cultures of various racial/ethnic groups. A result of our planning process, PEI funds will be utilized to support these services.

**LGBTQ Services:** Increased access to culturally and linguistically sensitive mental health services for the LGBTQ Community is created by conducting annual staff/provider training to decrease stigma and increase awareness and comfort level on LGBTQ issues, data collection on the LGBTQ community, ongoing outreach and education to be inclusive of the LGBTQ community, and partnerships with LGBTQ advocacy organizations. As a result of our planning process, PEI funds will be utilized to support these services.

**Chinatown Learning Center** (Interim, Inc. and CSU Monterey Bay) Community-based wellness and recovery services for adults who are currently homeless and who also may have serious mental illness and/or substance abuse disorder.

**Family Self-Help Support and Advocacy:** NAMI Monterey County provides individual and group support, outreach services, family-to-family education courses for family members and care providers of adults living with mental illness, “provider education” presentations to mental health professionals, and anti-stigma campaigns throughout the county. Additional PEI funds aim to expand these services to residents who live in South County.

**Epicenter/Voices:** The youth-led community center provides resources and counseling for youth, ages 16-24, especially those who are transitioning out of foster care. Services include information, referral and linkage, coaching and mentoring, training, healthy eating and lifestyle education, outreach and relationship building with system partners, development and sustainability of local volunteers, and development, partnership, and support around various Individual Living Program (ILP)-related special events and experiences, emphasizing employment and education opportunities. Because of our planning process, PEI funds will be utilized to support these services.

**PEI Funds to CalMHSA for Statewide PEI Projects:** BHB will continue to partner with CalMHSA to implement, statewide, initiatives: Each Mind Matters, Know the Signs, Walk in Our Shoes, and Direct Change, to reduce stigma and discrimination, improve student mental health, and prevent suicide. Education and public health messages act to prevent suicide and link Monterey County residents with key information about how to seek help. Because of our planning process, PEI funds will be utilized to support these services.

**Prevention and Recovery in Early Psychosis (Felton Institute):** Prevention and Recovery in Early Psychosis (PREP) Monterey County serves individuals between the ages of 14-35, with first onset of Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder or Psychosis Not Otherwise Specified (NOS), within the past two years. The Goals of PREP Services are: 1) Remission: fewer hospitalizations, a remission of psychotic symptoms, and return to a normal life of school, work, family, and friends; 2) Rehabilitation: provide early psychosis clients with the tools they need to continue to keep their illness under control for the long term; 3) Recovery: restores clients to a normal productive life; and 4) Respect: all treatment planning will include participation and consent by the client and his/her family (as defined by the client). Because of our planning process, PEI funds will be utilized to support these services.
Mental Health First Aid: In collaboration with the Monterey County Office of Education (MCOE), the BHB Bureau is offering Mental Health First Aid courses. These courses teach a 5-step action plan to help people showing signs of a mental illness or in a crisis, and connect them with the appropriate professional, peer, social, or self-help care. The eight-hour course is available for anyone 18 years and older, who wants to learn how to help a person who may be experiencing a mental health crisis or problem and/or who works with young people, ages 12-18. This includes teachers, coaches, leaders of faith communities, social workers, and other caring citizens. As a result of our planning process, PEI funds will be utilized to support these services.

Trauma Exposed Individuals

Child Advocacy Program (Monterey County Probation Department): This program is a collaborative of 13 community partners. It provides community-based prevention and intervention services to families with children under the age of five, who have witnessed or been subjected to domestic violence. Services include: home visits, social and emotional development screening, information and referrals to community services and emergency assistance.

School Based Domestic Violence Counseling or Sticks & Stones (Harmony at Home): Services are provided by licensed clinicians or qualified interns for schools on behalf of children who have witnessed violence or other traumatic events. Counselors provide individual and group therapy, utilizing various evidence-based practice theories such as expressive arts, and make referrals to other resources.

Critical Incident Debriefing: This program provides individuals who have been traumatized by witnessing violence or a traumatic incident with needed professional assistance. Debriefings are conducted on or near the site of the violent or traumatic incident, usually within a 24- to 72-hour period.

Suicide Prevention (Family Service Agency of the Central Coast): The expansion of the Suicide Prevention Line has increased the capacity for a 24-hour, toll-free, multi-lingual suicide-crisis line that ensures services are accessible to all residents at-risk of suicide. Services include: crisis intervention, information and referral, support group information and collaboration with community-service agencies.

Mental Health Services for the Archer Child Advocacy Center: This program serves as an early-intervention effort to mitigate the long-term effects of child abuse. The program provides mental-health assessments, referral, and brief therapy to children who have been sexually assaulted, and provides crisis support to the child’s family. Providing brief therapy at an early stage, immediately following the exposure to abuse and trauma, helps reduce the development of severe emotional disturbance or serious mental illness.

Resolving Trauma Services for Children (Kinship Center): The focus of these mental health services is to resolve trauma experiences for infants and children, ages 0 through 5 years, by addressing the impact of trauma on a child and their family, as well as the impact of trauma on
children who are being raised by a relative caregiver. Such services will help reduce the possibility of future residential care, periodic inpatient hospitalization, placement at out-of-home facilities, or placement in a juvenile detention facility. Because of our planning process, PEI funds will be utilized to support these services.

**Veterans Reintegration Transition Program (VRTP):** The Veterans Transition Center (VTC), Salvation Army (SA), Department of Social Services (DSS) faith-based organizations, law enforcement, training and job-placement agencies partner to help Veterans reintegrate into their community after they are released from service. Veterans service representatives for the MVAO Veteran Reintegration Transition Program (VRTP VSR), communicate regularly with non-profit and veteran organizations within the community to provide support and services to Veterans. They also act as mentors for returning service members, providing their experience and guidance to help them deal with today’s major conflicts. VTRP VSRs also reach out Veterans who are in shelters, on the street, or in local correctional facilities to help with mental health, healthcare and social-service referrals. As a result of our planning process, PEI funds will be utilized to support these services.

**Services for Women with Postpartum Depression:** The Postpartum Wellness Program is offered as a year-round service to improve the wellbeing of new moms and babies, by providing a supportive, kind environment to talk about depression and anxiety during pregnancy and after birth. It is a single point of access for women who are privately insured, publicly insured on Medi-Cal, or uninsured. The Postpartum Warm line is a free, confidential, 24-hour voicemail. Bilingual counselors are on call to return calls, offer a listening ear, conduct a postpartum screening as appropriate, and make referrals to appropriate follow-up care. Postpartum support groups are held twice a month at locations in Marina and Salinas. The groups are facilitated by a counselor who has extensive training in perinatal mood disorders. BHB will add additional support via the Early Intervention team. Because of our planning process, PEI funds will be utilized to support these services.

**Children and Youth in Stressed Families**

**Kinship Center:** This program provides outpatient mental-health services to children and their families, referred by the Department of Social Services, other BHB programs, and the community. Mental health services are designed to provide reduction of mental disability, and improve and maintain functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency.

**Youth at Risk of Juvenile Justice Involvement - Youth Diversion:** This program is a partnership between law enforcement, schools and BHB to intervene in the early incidence of juvenile delinquency. The program serves youth at risk of school failure and/or juvenile justice system involvement by providing assessment of emotional and mental health needs, counseling and referrals to community resources.

**WET Plan Strategies/Objectives/Actions:**

- Staff development and training support
B. List the strategies identified for each targeted area as noted in Criterion 2 in the following sections:

- **Provide annual trainings and ongoing consultations to develop staff competencies**
  - Incorporate into trainings specific cultural, gender, economic and spiritual issues
  - Provide translation-and-interpretation services for non-English-speaking trainees who are direct services providers
  - Provide orientation to all new BHB staff around service needs of a multicultural and diverse community
  - Ensure translation-and-interpretation services are available whenever necessary

- **Consumer and family-member training**
  - Provide training that incorporates the principles of wellness, recovery, and resilience
  - Provide training that motivates and empowers consumers and family members to participate in youth-guided, consumer-informed, and family-driven systems

- **Workforce development specialist (through CBO partner, Interim Inc.)**
  - Provides support groups for vocational support of consumers and family members who are employed in the public mental-health system
  - Provide individual job support to consumers, to include job coaching, benefits-counseling referrals, negotiation of reasonable accommodations, and individual counseling.

- **California State University Monterey Bay (CSUMB) Master of Social Work (MSW) Program**
  - Partner with CSUMB and other community partners to incorporate regional community needs into the MSW program.
  - Participate in community advisory board, field-placement subcommittees and resource development subcommittees.
  - Coordinate field placements for current MSW students and bachelor-level students.

- **Stipends and incentives**
  - Partner with Health Professional Education Foundation to increase local applicants for the Mental Health Loan Assumption Program and the Licensed Mental Health Service Provider Education Program.

- **Law Enforcement/First Responder Crisis Intervention (CIT)**
  - Training offered to increase law enforcement personnel, fire personnel, dispatchers and other emergency-response personnel-training in CIT.
  - Help increase awareness of signs and symptoms of mental illness and behavioral disorders.
  - Decrease stigma associated with mental illness or behavioral disorders.
  - Decrease the use of force, and minimize risk of harm in crisis situations.
  - Decrease asset rates for non-criminal behaviors.
  - Help provide an integrated service experience for those served by law enforcement, emergency response and mental-health personnel.
II. Medi-Cal population
The Health Department and stakeholder efforts have focused on expanding Medi-Cal coverage for eligible Monterey County residents. The expansion of coverage creates additional eligible beneficiaries; giving BHB access to even more individuals. Some of the strategies designed to attract this population are stated below.

- To target hard-to-reach areas of the County, such as the South County region, BHB has integrated mental-health services in County Clinic Services to ensure more readily available access.
- Salinas Clinics have expanded walk-in hours from one ½ day each week, to five full days a week.
- BHB has hired additional staff to expand services to school settings in collaboration with school districts. These services are being offered countywide.
- Substance-use-disorder services are available through the Medi-Cal 1115 Waiver.
- BHB is working to increase the rate of services for the African American and Hispanic/Latino communities, which represent the largest portion of the Medi-Cal population.

III. 200% below the poverty level
Services for community members who fall under the 200% percent poverty level are present, although limited. To address the needs of these individuals and those who do not have Medi-Cal, BHB has included consultation at the point of access, and treatment with short-term groups to develop coping skills for living with depression, anxiety, adjustment problems, and stress management.

For individuals in this category who do have Medi-Cal, services available through BHB can be provided once they qualify (i.e. meet medical need for services either through Children Services or Adult Services). See below in IV for information on services for those who do not have Medi-Cal.

IV. MHSA/CSS population
BHB has implemented many services with the use of MHSA funding for individuals who do not qualify for, or do not desire the services BHB offers. The CSS planning process clearly identified the need to provide trainings and support groups. BHB has partnered with Community Human Services to make these opportunities available. MHSA funds were used to ensure that individuals contacted by the Monterey County Department of Social & Employment Services, who do not meet the threshold for substantiation of neglect or abuse intervention but need additional mental health services, get them. These services are available to families in need of early-mental-health intervention. The OMNI Center, which offers support groups and resources to consumers and their families, is also funded with MHSA funds. This center has branched out to make support groups available to consumers and family members located in East Salinas, an area predominantly populated with migrant families, and which has no BHB clinic or site.

V. PEI priority population(s) selected by the county, from the six PEI priority populations
The three PEI priority areas identified by the County are: 1) access and linkage to treatment 2) Improve timely access to services for underserved populations 3) Non-stigmatizing and non-discriminatory practices. Programs like the Peer Support Wellness Navigation helps link clients to resources and supports clients that are in a transition from residential treatment into the community post program completion. The Navigator’s role includes helping clients complete screening tools and explain program available to them.

The Epicenter is another program that supports linkage to services to the LGBTQ community. This youth-led community center, provides resources and counseling for youth, ages 16-24. Services include information, support services, referrals and linkages, coaching and mentoring, mental and physical health, and wellness.

Additional programs that support PEI’s priority areas include:

- Critical Incident Training for law enforcement and first responders.
- Targeted outreach and service for the African American, Hispanic/Latino immigrants and LGBTQ communities has been implemented through contracts with community providers.
- The Village Project, based in Seaside, reaches out to serve the African American Community.
- The Promotores project through the Center for Community Advocacy reaches out to serve the monolingual Hispanic/Latino farmworker community in collaboration with credible agencies that have experience with this population.
- Efforts to develop outreach and services to the Native American and Asian Pacific Islander Communities need additional planning to effectively engage these communities with culturally based services designed by members of these communities.

Each of these efforts, designed to address the specific needs of the communities of focus, has a limited capacity, yet has been developed with the clear intention to reduce disparities and transform the effectiveness of the mental-health system. Each program is integrated with cultural foundations designed to improve access to and support for these populations. More detail on each program can be found in Criterion 3, Section III A. Pg. 40.

**IV. ADDITIONAL STRATEGIES/OBJECTIVES/ACTIONS/TIMELINES AND LESSONS LEARNED**

**A. List any new strategies not included in Medi-Cal, CSS, WET, and PEI. Note: New strategies must be related to the analysis completed in Criterion 2.**

BHB will continue to develop new partnerships to help address the disparities identified within the target populations and will add any new actions identified to the next plan update.

**B. Share what has been working well and lessons learned through the process of the county’s development of strategies, objectives, actions, and timelines that work to reduce disparities in the county’s identified populations within the target populations of Medi-Cal, CSS, WET, and PEI.**
The following are descriptions of activities that have been working well and are aiding in the reduction of disparities in the county’s identified populations. The following are a list of BHB 2017 accomplishments:

**Walk-Ins:** In 2016 we recognized the success of “Walk in Wednesdays”, and expanded those services to daily walk-in services to improve access to services without a need for an appointment. All regions provide walk-in services with varied dates and times, based on geographic need.

“Walk-in” enable individuals and families with or without Medi-Cal to consult with clinical staff. Initial screening services include meeting with a clinician to conduct an intake assessment and an orientation to mental-health services. After the initial assessment, clients are scheduled for a comprehensive evaluation. In situations where an individual with Medi-Cal meets the Medi-Cal Necessity Criteria and would benefit from additional services, he or she is scheduled for an assessment, and a referral is made to services provided by BHB or its contractors. If an individual is not Medi-Cal eligible, he or she is referred to community services, including some BHB contractors which may provide the services on a sliding scale.

The expansion of services and access to them, particularly in South County, has resulted in a slight reduction in the barriers impeding access to mental-health services. Now, South County residents, along with the other regions of the County, are afforded increased availability of services. The BHB clinic system is expanding to continue to facilitate access to services and to guide people through a more accommodating system. This means Medi-Cal eligible individuals can have assessments and orientation to BHB services without an appointment, on a first-come, first-served basis. Individuals without medical insurance also have an opportunity to discuss their mental health needs with a social worker who can link them to other resources in their own community.

This increased service capacity enables BHB to serve unserved children, families, adults and older adults. If the medical director determines a client needs an appointment with a psychiatrist for medication, evaluation and/or treatment, an appointment is immediately provided. The psychosocial assessment also serves to determine if an individual meets the Children or Adult System of Care criteria. Criteria. Once eligibility for either system is determined, BHB staff will refer the client to one of the two systems.

In addition to the South County clinics, BHB opened Integrated Healthcare Services in Marina. Having relocated from Monterey to a more central location, the Marina clinic now serves the Monterey Peninsula. This improves accessibility for residents of Castroville and Moss Landing, who may prefer to travel to Marina versus Salinas for services. Yet, it is close enough for easy access by residents of Seaside, Monterey and Pacific Grove. The Marina clinic is used by Interim, Inc., Shelter Outreach Plus, and County Health Clinics. This shared facility allows for a coordinated service provision, where a client may come in for a medical appointment and be referred for mental health, homeless or other support services. Access to services may begin through any of the providers, and clients can be referred to appropriate services without having to leave the building.
Access to Treatment: The original CSS plan identified the need to increase access to BHB services throughout the County. In July 2009, State budget reductions ceased funding for outpatient Mental Health Managed Care Programs, so counties were no longer required to provide this service. However, due to BHB’s commitment to address the needs of the underserved and unserved communities, BHB decided to redesign the Managed Care Program with MHSA dollars to continue providing services to the county’s Medi-Cal eligible population. This important decision originated the “Access to Treatment” program.

As stated in the BHB’s 2014 Strategic Plan, the main goal of the “Access to Treatment” program is to facilitate access to mental-health services to eligible individuals. After initial assessment, treatment services usually are provided in group settings and/or individual counseling sessions. The purpose of the program is to ensure people in need receive access to appropriate services in a timely and comprehensive manner.

When accessing treatment, individuals are attended to immediately by a staff member, able to assess their mental-health needs, connect them to appropriate services and/or invite them to participate in treatment at one of the three regional locations. Clients can now access mental-health services closer to their place of residence, whether they live in South County, the coastal region or in the Salinas Valley. Counseling services also are offered in the Castroville and North County area.

Wellness Peer Navigation: Peer Support resources are used in the Adult System of Care. Peers come from a lived experience background and can provide an additional support for those clients that need more support.

Family Support Groups: The Adult System of Care currently has family support groups offered daily in Spanish and English. These are run by clinical social workers and are open to consumers and family members of consumers.

Sobering Center: Grant funding from Proposition 47 were used to open a sobering center in Salinas. This is a safe place where individuals are who are intoxicated in public, or are on an illegal or illicit substance are brought in by law enforcement for “sobering” instead of being placed into custody. This takes the burden off our incarceration facilitates. BHB had a “soft start” the end of December 2017 and will be open for business early 2018.

Integrated Health Clinics: One of the newest cultural competence strategies implemented by the Monterey County Health Department, with BHB and its County Clinic system, to expand access to treatment is the integration of primary healthcare and BHB services. Currently, services are integrated at two locations: the Bienestar Clinic at Natividad Medical Center (NMC) in Salinas, and at the Marina Integrated Clinic. Both locations are staffed by a primary-care provider, a medical assistant, one integration coordinator, and two wellness navigators.

A psychiatric nurse practitioner is on site two days a week (Monday and Tuesdays in Marina from 8:00 am to 5:00 pm and Wednesdays and Thursdays at NMC from 8:00 am to 5:00 pm). These
clinics give patients the opportunity to address their primary-care concerns and their behavioral health needs in the convenience of one appointment. Creating the capacity to treat patients with mental and primary care needs during one visit, increases efficiency, convenience and access.

Tele-Therapy: BHB has contracted with USC bilingual therapists and psychiatrists to fill in gaps produced by our workforce capacity gap. This service has been beneficial in reaching the Southern part of the County and for those clients that prefer this therapy option. Currently, all our clinics have computers and a space to hold private individual therapy sessions, and clients can come into the clinics and have their session there. However, we are exploring the idea of consumers using their personal devices to connect to their therapist. This option could be for those that prefer their sessions in the privacy of their home and/or have other barriers preventing them from coming to the clinic.

Electronic Health Record (EMR): In late 2009, BHB rolled out its electronic health record system, Avatar. Program admissions and services now are electronically documented in the system by all BHB providers. This technology has helped improve the quality and efficiency of services by enabling clinicians and therapists to access client’s records from anywhere in the County. Having all data in a central location also helps reduce errors and eliminates redundant data entry.

Avatar also enables BHB to track progress and service rates to determine where disparity remains, and to analyze issues that prevent access to treatment. Application of this system has created a network of informed providers, working together to reduce disparities, identify barriers and create solutions to ensure accessible, culturally competent service.

Community Outreach: The Health Department and BHB have increased the number of community outreach events and community involvement opportunities for Monterey County residents. Below is a summary of practices utilized by the Department:

1. Social marketing and communication efforts are developed for clients/family members.
2. Bi-lingual, culturally competent outreach materials are developed and distributed. Materials include flyers, newsletters and videos, Access to Treatment postcards, tip sheets, links to additional information and resources. The materials and website are available in English and Spanish.
3. Community-outreach events, such as annual Family Fun Day, attended by more than 500 family members, increase public awareness of available BHB programs. Community presentations at the Maya Cinema, showcasing bilingual Digital Stories and documentaries that address mental health issues help to provide information to the community regarding mental health issues and available services and support. Conversations that follow these screenings help to reduce stigma in the community.
4. Community forums in Chualar and East Salinas provided information on how to minimize or prevent behavioral health problems and how to access services. Clinicians experienced in working in the Latino Community conducted the forums in Spanish, using dialogue as a tool to encourage parents and provide them with skills to support their children having difficulties. The forums provided an opportunity for parents to learn and to ask questions specific to their concerns.
5. Early-intervention programs provide services to young children and their parents. BHB partners with Headstart to provide mental health consultation to early childhood centers. MCSTART provides specialized services to Medi-Cal-eligible children, ages 0-5 and their parents/caregivers, especially children exposed to drugs/alcohol in utero.

6. Inclusion of youth/clients/parents in program planning and evaluation through participation in Family Partnership and the Avanza Youth Group helps ensure their needs will be addressed. Both are consumer/family member-led efforts to support families and TAY consumers interested in supportive activities beyond treatment services.

7. To increase access for TAY, Avanza takes self-referrals. BHB staff has presented to community groups, such as the Latino Social Work Network, to help ensure that youth know how to access available programs and services. Having youth participate in presentations provides insight for young people and service practitioners during the MHSA planning process.

8. Family partners are bi-lingual and bi-cultural. Their work includes partnering with monolingual Spanish-speaking parents to help them understand the BHB system and what they can expect from BHB. They serve as a liaison and help to engage families from underserved and unserved communities.

Specific Racial/Ethnic/Cultural Groups: As mentioned throughout the plan, BHB contracts with organizations specializing in the provision of services to specific racial, ethnic, and cultural populations:

African Americans: The Village Project was designed to support African American youth and families through outpatient programming that integrates culturally specific values, traditions, and interventions. The organization is nonprofit developed with the support of PEI funding and umbrella infrastructure support by the Community Action Council. The Village Project has developed a broad referral network of schools, social-service agencies, community-based volunteer organizations, individuals, families and peer referrals.

Located in Seaside, a community that is home to a large proportion of African Americans in Monterey County, the organization has expanded its offerings from contract-based services to additional services supported by other funding streams, grants and donations.

The Village Project provides culturally based mental-health training of interns interested in working with the African American Community. The program is designed with African American cultural values and culturally specific interventions; however, it also has become a neighborhood access point for all community residents interested in BHB services for their youth and families.

Spanish Speaking Farmworkers: BHB contracts with two community-based organizations that involve reaching out to the community through Promotores. The Center for Community Advocacy (CCA) has a long history of developing and training volunteer promoters or “promotores” in various neighborhoods in the community. BHB’s contract with CCA enables their Promotores to learn about behavioral health issues and resources to integrate into their community outreach and presentations.
Promotores receive training and health-and-social services information for their neighbors in various housing projects, which includes nutrition, self-care, stigma reduction and stress reduction provided by the BHB psychiatrist who implements the Alternative Medicine program. Promotores integrate their knowledge into presentations and information-sharing activities in their own neighborhoods. They also directly refer those in need of more specialized mental-health services to a specifically assigned BHB access clinician. The individual or family member, Promotores and BHB clinician work together to facilitate access to services, including individual and family counseling. The close collaboration between the Promotores and the BHB clinician has created an effective referral process that helps an individual or family access mental-health services and overcome issues of stigma.

The Central Coast Citizenship Project (CCCP) also contracts with BHB for Promotores services, but with different approach. The CCCP provides mental-health training to Promotores and outreach workers in community organizations. The CCCP staffing includes a Licensed Marriage and Family Therapist (LMFT), who provides training and individual/group and family counseling for Spanish-speaking individuals and families who do not have Medi-Cal insurance coverage. The LMFT refers individuals and families who require more specialized services, to the same BHB clinician working with the CCA project. The CCA clinician also participates with BHB community forums for parents, usually held in local schools.

Both Promotores programs focus on the Spanish-speaking farmworker community in Monterey County. Both have access to more specialized services and BHB training activities. Both programs have long histories of working in the community and are trusted organizations among the Spanish-speaking community. Both have extensive community referral networks and serve as a bridge to services for the community and for BHB to the Latino community.

**LGBTQ:**
Recently established nonprofit, the Epicenter, further assists in the provision of services to the LGBTQ community. This youth-led community center provides resources and counseling for youth, ages 16-24. Services include information, support services, referrals and linkages, coaching and mentoring, mental and physical health, and wellness.

**V. PLANNING AND MONITORING OF IDENTIFIED STRATEGIES/OBJECTIVES/ACTIONS/TIMELINES TO REDUCE MENTAL HEALTH DISPARITIES**

A. **List the strategies/objectives/actions/timelines provided in Section III and IV above and provide the status of the county’s implementation efforts (i.e. timelines, milestones, etc.).**

All the programs mentioned above are currently operational. The culturally specific programs have helped BHB make inroads in reducing disparities. It is BHB’s intention to support continued efforts to reduce disparities among the vulnerable and underserved communities in Monterey County and to expand access to them as resources allow.
Programs report results of activities, both direct and through outreach, in their quarterly reports. BHB is trying to develop its reporting mechanisms using the Avatar data system to allow for more consistent monitoring and measuring of outreach activities and contacts. The Cultural Competency Coordinator will work closely with the Avatar information technology staff to develop culturally competent-related benchmarks for programs, to ensure that measurable objectives are monitored on a regular basis.

Regular reports will be developed to measure progress in reducing service disparities. With the Avatar database in place, we can now generate reports that show disparities in specific programs and then develop training or other resolutions to address issues.

**B. Discuss the mechanism(s) the county will have or has in place to measure and monitor the effect of the identified strategies, objectives, actions, and timelines on reducing disparities identified in Section II of Criterion 3. Discuss what measures and activities the county uses to monitor the reduction or elimination of disparities.**

With the Avatar data system in place and staff trained to take reports from the system, staff are now able to monitor and track more closely the results of their service delivery and penetration progress. Reports and progress will be analyzed to evaluate and improve strategies, and will be shared with the CRHC to receive input and feedback. The CRHC will work to develop a work plan that will include matrices and benchmarks. Reports will be shared with QI, Management, the Mental Health Commission, consumers/family members and stakeholders. The reports also will be posted on the BHB website on an annual basis.

**C. Identify county technical assistance needs.**

Technical assistance would be helpful in developing reporting mechanisms for measuring impact of outreach, stigma reduction and prevention activities where episodes are not typically opened on contacts. Technical assistance in comparing outcomes of specific cultural interventions would be useful to ensure consistency with other similar projects in the state. Technical assistance in gathering input from persons/families who discontinue services would be helpful in recognizing what people who drop out of service would need to return to service.
The BHB’s Cultural Relevancy and Humility Committee (CRHC) is composed of BHB staff, contracted providers, local non-profit representatives, consumers and their family members/support persons, and other community stakeholders. The committee is chaired by the Health Equity & Cultural Competency Coordinator. It meets on the first Friday of each month with the purpose of providing input on how the County can better provide equitable health services, review and provide feedback on County documents and policies, and identify gaps in service delivery.

In June 2015, the committee convened to redefine its mission and goals. Listed below are the latest mission statement, vision statement, function, and goals of the committee.

**Mission**: The Cultural Humility and Relevancy Committee is working to provide a holistic approach to bring equitable service to all community members in Monterey County through cultural awareness and education.

**Vision Statement**: To ensure all Monterey County residents will have equal opportunity to reach their full health potential.

**Functions**:
1. Obtain an effective communication plan with deputy directors and health directors
2. Review and create policies
3. Receive group training for ongoing learning of culturally competent practices
4. Collaborate with others on local, regional and state levels
5. Create outcome measures, evaluations and tracking documents
6. Create networks and facilitate community outreach

**Goals**:
1. Develop relationships with BHB staff and Directors
2. Train the committee for three to six months
3. Develop a network for unrepresented cultures
4) Provide feedback and reviews of key documents as well as give input for improvement
2) Encourage others to join the committee

**B. Policies, procedures and practices that assure members of the Cultural Competence Committee will be reflective of the community, including county management level and line staff, clients and family members from ethnic, racial, and cultural groups, providers, community partners, contractors, and other members as necessary;**

All contract providers are encouraged to participate in the CRHC. Committee meetings are held at the peer-run First United Methodist Church, which operates a homeless services center out of their facilities and is in Salinas, and at the health department headquarters. Participation on the committee by various sectors of the community is highly encouraged. The committee is continuously seeking participation by staff, community partners, consumers, family members and local activists, working to increase mental health and wellness for all.

One of the key functions of members is to support the expansion of the committee to include representation of unrepresented cultures and encourage others to join the group to include fresh insights from the community.

In the section below an organizational chart for the BHB and the CRHC Roster for 2016-2017 can be found. The roster is inclusive of consumer and family-member of consumers, community organizations, stakeholders, BHB and Health department staff.

**C. Organizational chart**

*Figure 3: Monterey County Behavioral Health Organizational Chart 2016*
Table 10: Cultural Competence Resource Team

<table>
<thead>
<tr>
<th>Area</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Linguistic Access</strong></td>
<td>Lucero Robles</td>
</tr>
<tr>
<td><strong>Workforce Development, Education &amp; Training:</strong></td>
<td>Jill Walker</td>
</tr>
<tr>
<td><strong>Partnership with multicultural Communities</strong></td>
<td>Carmen Gil, Christina Santana, Alica Hendricks, and Dana Edgull</td>
</tr>
<tr>
<td><strong>Governance, Systems and Policy</strong></td>
<td>Christina Santana</td>
</tr>
<tr>
<td><strong>Data Collection</strong></td>
<td>Lucero Robles</td>
</tr>
<tr>
<td><strong>Inclusion Initiative (LGBTQ)</strong></td>
<td>Rose Moreno, Jill Walker and Christina Santana</td>
</tr>
</tbody>
</table>
Below is the listing of everyone who participated in the CRHC meetings in 2017.

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization/Agency</th>
<th>Email</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alica Hendricks</td>
<td>MCHD, Behavioral Health</td>
<td><a href="mailto:hendricksa@co.monterey.ca.us">hendricksa@co.monterey.ca.us</a></td>
<td>(831) 796-1295</td>
</tr>
<tr>
<td>Amanda Mihalko</td>
<td>MCHD, Public Health</td>
<td><a href="mailto:mihalkoa@co.monterey.ca.us">mihalkoa@co.monterey.ca.us</a></td>
<td>(831) 755-4626</td>
</tr>
<tr>
<td>Amie Miller</td>
<td>MCHD, Behavioral Health</td>
<td><a href="mailto:milleras@co.monterey.ca.us">milleras@co.monterey.ca.us</a></td>
<td>(831) 755-4580</td>
</tr>
<tr>
<td>Ana Reyna-Leyva</td>
<td>MCHD, Admin</td>
<td><a href="mailto:Reyna-leyvaa@co.monterey.ca.us">Reyna-leyvaa@co.monterey.ca.us</a></td>
<td>(831) 755-4323</td>
</tr>
<tr>
<td>Ana Vargas</td>
<td>MCHD, Admin</td>
<td><a href="mailto:vargasasa@co.monterey.ca.us">vargasasa@co.monterey.ca.us</a></td>
<td></td>
</tr>
<tr>
<td>Angelica Chavez</td>
<td>MCHD, Admin</td>
<td><a href="mailto:Chaveza1@co.monterey.ca.us">Chaveza1@co.monterey.ca.us</a></td>
<td>(831) 755-4514</td>
</tr>
<tr>
<td>Blanca Taverna</td>
<td>Matrix Consultant</td>
<td><a href="mailto:blanca@cruzio.com">blanca@cruzio.com</a></td>
<td></td>
</tr>
<tr>
<td>Carmen Gil</td>
<td>MCHD, Admin</td>
<td><a href="mailto:GilC@co.monterey.ca.us">GilC@co.monterey.ca.us</a></td>
<td>(831) 755-8997</td>
</tr>
<tr>
<td>Caty Gutierrez</td>
<td>Community Member</td>
<td></td>
<td>(831) 682-2228</td>
</tr>
<tr>
<td>Cesar Anaya</td>
<td>MCHD, Behavioral Health QI</td>
<td><a href="mailto:AnayaCG@co.monterey.ca.us">AnayaCG@co.monterey.ca.us</a></td>
<td>(831) 755-4545</td>
</tr>
<tr>
<td>Christina Santana</td>
<td>MCHD, Admin</td>
<td><a href="mailto:santanac@co.monterey.ca.us">santanac@co.monterey.ca.us</a></td>
<td>(831) 755-4855</td>
</tr>
<tr>
<td>Colleen Beye</td>
<td>EOO</td>
<td><a href="mailto:beyec@co.monterey.ca.us">beyec@co.monterey.ca.us</a></td>
<td></td>
</tr>
<tr>
<td>Dana Edgull</td>
<td>Behavioral Health</td>
<td><a href="mailto:edgulldr@co.monterey.ca.us">edgulldr@co.monterey.ca.us</a></td>
<td>(831) 796-6110</td>
</tr>
<tr>
<td>Devonte Taylor</td>
<td>Community Member</td>
<td></td>
<td>(831) 383-2236</td>
</tr>
<tr>
<td>Elizabeth Ambriz</td>
<td>MCHD, Admin</td>
<td><a href="mailto:ambrize@co.monterey.ca.us">ambrize@co.monterey.ca.us</a></td>
<td>(831) 755-4581</td>
</tr>
<tr>
<td>Erika Matadamas</td>
<td>MC Boys &amp; Girls Club</td>
<td><a href="mailto:ematadamas@bgcmc.org">ematadamas@bgcmc.org</a></td>
<td>(831) 394-5171</td>
</tr>
<tr>
<td>Ezzard McCall</td>
<td>Community Member</td>
<td><a href="mailto:dreadmanentertainment@gmail.com">dreadmanentertainment@gmail.com</a></td>
<td>(831) 737-7940</td>
</tr>
<tr>
<td>Name</td>
<td>Title/Role</td>
<td>Email</td>
<td>Phone</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------</td>
<td>--------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Gloria de la Rosa</td>
<td>Community Member</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jackie Townsend</td>
<td>MCHD, Behavioral Health</td>
<td><a href="mailto:townsendj@co.monterey.ca.us">townsendj@co.monterey.ca.us</a></td>
<td>(831) 755-4545</td>
</tr>
<tr>
<td>Jesse Herrera</td>
<td>Community Member</td>
<td><a href="mailto:chuylcsw@co.monterey.ca.us">chuylcsw@co.monterey.ca.us</a></td>
<td></td>
</tr>
<tr>
<td>Jill Allen</td>
<td>Dorothy’s Place</td>
<td><a href="mailto:Jill.allen@dorothysplace.org">Jill.allen@dorothysplace.org</a></td>
<td></td>
</tr>
<tr>
<td>Jill Walker</td>
<td>MCHD, Behavioral Health</td>
<td><a href="mailto:Walkerj@co.monterey.ca.us">Walkerj@co.monterey.ca.us</a></td>
<td></td>
</tr>
<tr>
<td>Julie Allen</td>
<td>Psynergy</td>
<td><a href="mailto:jallen@psynergy.org">jallen@psynergy.org</a></td>
<td>(408) 465-8280</td>
</tr>
<tr>
<td>Joel Hernandez</td>
<td>Center for Community Advocacy</td>
<td><a href="mailto:jherandez@cca-viva.org">jherandez@cca-viva.org</a></td>
<td></td>
</tr>
<tr>
<td>Karen Contreras</td>
<td>Community Member</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kontrena McPheter</td>
<td>Interim Inc.</td>
<td><a href="mailto:kmcppheter@interiminc.org">kmcppheter@interiminc.org</a></td>
<td>800-7530x408</td>
</tr>
<tr>
<td>Krista Hanni</td>
<td>MCHD, Admin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Judith Aguilera</td>
<td>Community Member</td>
<td></td>
<td>(831) 710-1232</td>
</tr>
<tr>
<td>Laurel May</td>
<td>MCHD, Admin</td>
<td><a href="mailto:mayl@co.monterey.ca.us">mayl@co.monterey.ca.us</a></td>
<td>(831) 332-2865</td>
</tr>
<tr>
<td>Levonne Stone</td>
<td>Community Member</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leticia Folwer</td>
<td>Door to Hope</td>
<td><a href="mailto:lettyf@doortohope.org">lettyf@doortohope.org</a></td>
<td></td>
</tr>
<tr>
<td>Lisa Corpuz</td>
<td>Interim, Inc.</td>
<td><a href="mailto:lcorpuz@interiminc.org">lcorpuz@interiminc.org</a></td>
<td>(831) 800-7530</td>
</tr>
<tr>
<td>Mae-Greene Smith</td>
<td>Community Member</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manny Gonzales</td>
<td>MC CAO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marisela Casas</td>
<td>CSUMB Intern, MCHD Admin</td>
<td><a href="mailto:casasm@co.monterey.ca.us">casasm@co.monterey.ca.us</a></td>
<td></td>
</tr>
<tr>
<td>Meg Kenley</td>
<td>Community Member</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Norma Ahedo</td>
<td>Center for Community Advocacy</td>
<td><a href="mailto:nahedo@cca-viva.org">nahedo@cca-viva.org</a></td>
<td>(831) 585-7219</td>
</tr>
<tr>
<td>Pamela Weston</td>
<td>Collective de Mujeres</td>
<td><a href="mailto:Spiriteyes41@yahoo.com">Spiriteyes41@yahoo.com</a></td>
<td>(510) 383-0244</td>
</tr>
<tr>
<td>Paula Lewycky</td>
<td>MCHD, Behavioral Health</td>
<td><a href="mailto:Lewycky@co.monterey.ca.us">Lewycky@co.monterey.ca.us</a></td>
<td>(831) 755-4509</td>
</tr>
<tr>
<td>Rita Acosta</td>
<td>Community Member</td>
<td><a href="mailto:ritaacosta@gmail.com">ritaacosta@gmail.com</a></td>
<td></td>
</tr>
<tr>
<td>Rose Luna Regalado</td>
<td>Community Member</td>
<td><a href="mailto:roselunaregalado@sbcglobal.net">roselunaregalado@sbcglobal.net</a></td>
<td>(831) 262-5286</td>
</tr>
</tbody>
</table>
# California Department of Mental Health Cultural Competence Plan Requirements

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Email</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rose Moreno</td>
<td>MCHD, Public Health</td>
<td><a href="mailto:morenor@co.monterey.ca.us">morenor@co.monterey.ca.us</a></td>
<td>(831) 755-4716</td>
</tr>
<tr>
<td>Rose Mary Soto</td>
<td>MC CAO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ruben Gabriel</td>
<td>MCHD, Behavioral Health QI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sabino Lopez</td>
<td>CCA</td>
<td><a href="mailto:Slopez@cca-viva.org">Slopez@cca-viva.org</a></td>
<td></td>
</tr>
<tr>
<td>Suzanne Battaglia</td>
<td>MCHD, Behavioral Health</td>
<td><a href="mailto:BattagliaSF@co.monterey.ca.us">BattagliaSF@co.monterey.ca.us</a></td>
<td>(831) 755-8155</td>
</tr>
<tr>
<td>Wes White</td>
<td>Community Member</td>
<td><a href="mailto:luckyagentwes@yahoo.com">luckyagentwes@yahoo.com</a></td>
<td></td>
</tr>
<tr>
<td>Yessica V. Rincon</td>
<td>MCHD, Behavioral Health</td>
<td><a href="mailto:rincony@co.monterey.ca.us">rincony@co.monterey.ca.us</a></td>
<td>(831) 784-2167</td>
</tr>
</tbody>
</table>
II. THE CULTURAL COMPETENCE COMMITTEE OR OTHER GROUP WITH RESPONSIBILITY FOR CULTURAL COMPETENCE, IS INTEGRATED WITHIN THE COUNTY MENTAL HEALTH SYSTEM

A. Evidence of policies, procedures, and practices that demonstrate the Cultural Competence Committee’s activities, including the following:

Members of the CRHC have been partners in the development of the CCS, PEI and MSHA plans, the MSHA 3-year update process. Since they represent a variety of community sectors, they are key stakeholders in the development of policies related to cultural competence. The committee has spent time reviewing the language of BHB agreements, with a focus on updating Exhibit E: Assurance of Compliance with Monterey County’s Cultural Competency Policy (shown in Appendix A) to ensure that BHB contractors are adhering to cultural competency requirements, are using best practices, and are keeping up with relevant trainings. They also participated in the development of this plan and were stakeholders throughout the process, including through the creation of key criteria.

In addition to reviewing policies, over the past year the CRHC has fully participated in the development of the Action Plan that responds to identified areas needing improvement. This intentional action was deployed to help inform the BHB on community driven solutions to needs prioritized by committee selected underserved, marginalized and hard-to-reach populations.

The Action Plan was informed by Behavioral Health’s 2014 Strategic Plan, MHSA 3-year update in addition to multiple CRHC and subcommittee meetings comprised of community members, consumer and family-member of consumers, stakeholders, BHB and Health department staff.

Staff and CRHC community members had several discussions connecting BH Strategic Plan and MHSA three-year updates, PEI, CSS and marginalized communities, and the Cultural Competency Plan Requirements report. The information was helpful to identify the groups highlighted in this report and develop key informant and focus group participant questions. The committee identified Spanish-Speaking/Farmworker Latinos, Homeless/Displaced, LGBT, African American/Black, Asian American/Pacific Islander, Deaf and Hard of Hearing and System Impacted Families as the focus population of this Action Plan. A CRHC subcommittee met twice a month to discuss data collection process, resources and efforts for the identified communities. Committee members became very active in this process and recruited participants, identified and secured safe locations for the participants, and facilitated and guided the focus groups.

There was a total of 7 focus groups (6 community and 1 of BH staff) with a total of 89 participants. They ranged in age, race/ethnicity and consumer and/or family consumer status. (Please note: The Deaf and Hard of Hearing was a key informant interview, as a focus group required resources that
we did not have). The BH staff focus group was conducted by the consultant. All the focus groups were completed between January-April 2017.

The 10 key one-to-one informant interviews were guided by the consultant. The informants were identified by focus group participants and other community members. All interviews were done in English (Deaf and Hard of Hearing signed in ASL), and 50% of them spoke another language other than English, and 40% were female. The interviews were completed between March-April 2017.

After the focus group were completed, facilitators for each of the focus group had a debriefing session with the consultant. In each of the focus groups had observers taking notes. The consultant reviewed the notes and identified overarching themes that captured the essence of community’s opinions. The consultant used the key informant interviews to identify historical and/or other relevant information that could impact communities wanting to receive BHB services. See Appendix H for focus group and Key informant interview questions.

The overarching themes that were identified resulted in three overarching priority areas, those include: 1) Improve Equity 2) Strengthen Collaboration and Partnership and 3) Institutionalize Cultural Relevancy Practice/Perspective. Each of the priority areas has a specific focus and action activities to support the work of moving towards equity. Please see Exhibit G for the entire report. It is the CRHC’s intention to move forward with agreed upon focus and action areas to support BHB in identifying better ways to serve the community.

Members assisted in presenting the Action Plan’s development to the Monterey County Mental Health Commission. The group continues to meet monthly and through workers, as needed.

**B. Provide evidence that the Cultural Competence Committee participates in the above review process.**

Attendance lists and meeting notes reflecting participation are maintained for each meeting. In addition, CRHC members, who participate in a specific plan development or program, report the activity at the committee meetings. All meeting minutes and agendas are available during site visits and audits. In addition to this process, BHB plans to develop a policy that addresses the direct connection between the CRHC and the Bureau.

The Action plan noted above was presented at the BHB managers meeting, Mental Health Commission and other community meetings and will help to prioritize resources and efforts starting in FY 2018.

**C. Annual Report of the Cultural Competence Committee’s activities:**
The CRHC has been regularly meeting and working steadily towards its goals. Many of the goals they set for themselves were met in 2015 and 2016. One specific goal accomplished was outreach and encourage others to join CRHC. Through these efforts, CRHC has been rejuvenated and has kept, added and brought back previous members, who are attending meetings on a regular basis. Members have actively engaged representatives of various communities, such as: homeless, LGBTQ, Latino, and African American communities. These new engagements have allowed for the creation of new networks and have given the department a broader reach into those specific populations.

The committee has been active in reviewing key Cultural Competency documents and have provided feedback for their improvement. For example, they reviewed MSHA update, Department culturally competent policy and procedures including valuable suggestions to the update of this plan and update of Exhibit E.

CRHC committee members have participated in trainings and community conversations about relevant issues, hosted by BHB through their PEI work. This practice will be carried into the next year; they will divide into workgroups during the next few months. The committee is interested in developing workgroups to delve deeper into specific areas of concern; a special focus group on issues related to homelessness. They will learn more about issues related to various topics and will utilize their findings to inform the cultural competence action plan under development.

Another CRHC achievement is the submission of this plan to the State and the completion of the Action Plan. The committee was an active participant in the creation of these documents and has followed the entire process. Committee members look forward to the next steps, which will be to work on the implementation of the Action Plan.

An area of continued focus for the CRHC is the development of relationships with Bureau Chiefs and Directors. During this past few years, BHB has seen a lot of changes, including the appointment of new BHB Chief, Dr. Amie Miller, and the appointment of new MCHD Director, Elsa Jimenez, MPH. With these changes, the committee will work to develop working relationships with the new directors as well as other key staff members.

In the upcoming year, the CRHC will be hard at work, moving the Action Plan forward by sharing it with key stakeholders and working with department heads to utilize its findings and recommendations. Updates of their work will be provided in the next Cultural Competence Plan.
CRITERION 5: COUNTY MENTAL HEALTH SYSTEM CULTURALLY COMPETENT TRAINING ACTIVITIES

Rationale: Staff education and training are crucial to ensuring culturally and linguistically appropriate services. All staff will interact with clients representing different countries or origins, acculturation levels, and social and economic standing. Staff refers not only to personnel employed by the organization but also its subcontracted and affiliated personnel (CLAS, Final Report).

I. THE COUNTY MENTAL HEALTH PLAN SHALL ENCOURAGE ALL STAFF AND CONTRACTORS TO RECEIVE CULTURAL COMPETENCE TRAININGS.

A. The County shall develop a three-year training plan for required cultural competence training that includes the following:

1. The projected number of staff who need the required cultural competence training. This number shall be unduplicated.

Monterey County recognizes the importance of training and developing its workforce. Approximately 130 unduplicated BHB staff will be required to complete a minimum of four (8) hours of cultural relevancy and humility training, annually. BHB recognizes the importance of continuous staff development and keeping up to date with the latest mental-health practices. To do that, BHB plans to include cultural competence components in each of the trainings offered. Staff to be trained include: County and contracted, unlicensed direct-service staff; licensed mental-health staff, psychiatrists, managers and support staff. Going forward, this will be a mandate for all Behavioral Health contracts in accordance with the newly implemented Exhibit E component.

2. Steps the County will take to provide required cultural competence training to 100% of their staff over a three-year period.

BHB currently employs 426 staff. It plans to reach the target of 100% of staff trained in cultural competence over a three-year period, by requiring County and contracted staff, including support staff working with clients, to receive four hours of cultural competence training each year. BHB’s contracted service providers also will be responsible for obtaining and providing the required four hours of cultural competence trainings to their staff. BHB management analysts and the Quality Improvement team will track completion of the required four hours of training on a regular basis, and will generate annual reports, and set reminders for those still needing to complete their hours. Trainings will be in the form of live trainings and online courses.

3. How cultural competence has been embedded into all trainings.

Jill Walker, the BHB manager is committed to including a direct focus on cultural competence, as she is an active member of the Governing for Racial Equity. Dr. Walker has begun to coordinate trainings and add cultural competence language and components to sponsored BHB trainings.
II. ANNUAL CULTURAL COMPETENCE TRAININGS

A. Please report on the cultural competence trainings for staff. Please list training, staff, and stakeholder attendance by function (If available, include if they are clients and/or family members)

The information requested for this item is included in the next several pages. The table provides a summary of the trainings, the number of staff and stakeholders in attendance, and the topic of those trainings. The most current BHB training calendar can be found here: http://qi.mtyhd.org/index.php/calendar-of-events/. The chart below describes, in detail, the trainings that have included cultural-competence components.

Table 12: DMH Cultural Competency Plan Requirements—Training Report 2014-2017

<table>
<thead>
<tr>
<th>Training Event</th>
<th>Description of Training</th>
<th>How Long</th>
<th># of Attendees &amp; Totals</th>
<th>Date</th>
<th>Name of Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>WET Mind, Body &amp; Spirit</td>
<td>Simple breathing exercises to center the mind and prepare the mind for meditation; a guided visualization of light; spiritual reading and discussion.</td>
<td>1 hour</td>
<td>20</td>
<td>01/27/2014</td>
<td>Gary Gibbs D.O.</td>
</tr>
<tr>
<td>WET -Eliminating Barriers</td>
<td>TETRIS Mission: To provide teachers and school staff with tools to identify, recognize, refer and support students with mental-health needs in a respectful and culturally responsive manner. These tools will help to break down the barriers to academic performance and attendance that may be displayed by students in emotional distress. Day 1 is a training opportunity that will focus on the early identification of mental-health issues and effective classroom and schoolwide strategies. Participants will be trained in the Eliminating Barriers to Learning (EBL)</td>
<td>12 hours</td>
<td>56</td>
<td>01/30-31/2014</td>
<td>Christina Borbely, Ph.D., RET Partners</td>
</tr>
<tr>
<td>Event Description</td>
<td>Location</td>
<td>Date</td>
<td>Instructor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>---------------------------------</td>
<td>------------</td>
<td>------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017 Update: Monterey County Cultural Competence Plan Requirements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>California Department of Mental Health Cultural Competence Plan Requirements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>WET – The Art of Compassion; Building the Self-Care Tool Kit</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students will learn how to identify issues of loss, change and trauma that can</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>create the stress response in the caregiving professions; identify signs,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>symptoms and responses to loss, trauma and change, including acute, delayed,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cumulative and occupational stress reactions for professional caregivers; practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>effective support measures in response to personal stress management and team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>stress management in the workplace; develop and practice self-awareness through</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>identification of specific needs and dynamics of the individual person; identify</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>family dynamics in stress at home and in the workplace, and develop effective</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>response tools; learn compassionate response and awareness of different cultural</td>
<td>6 Hours</td>
<td>02/14/2014</td>
<td>Janet Childs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>backgrounds in grief; identify and practice effective tools for self-care in the</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>response professions, specifically counseling professionals.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>WET – Mind, Body &amp; Spirit</strong></td>
<td></td>
<td>02/24/2014</td>
<td>Gary Gibbs D.O.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simple breathing exercises to center the mind and prepare the mind for meditation;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meditation - A guided visualization of light, spiritual reading and discussion.</td>
<td>1 Hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>WET – Mind, Body &amp; Spirit</strong></td>
<td></td>
<td>02/24/2014</td>
<td>Gary Gibbs D.O.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simple breathing exercises to center the mind and prepare the mind for meditation;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meditation - A guided visualization of light, spiritual reading and discussion.</td>
<td>1 Hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>**WET - Cultural Competence California; Brief Multi-cultural Competence, Santa</td>
<td></td>
<td>02/24-25/2014</td>
<td>Jei Africa &amp;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cruz County Foundation Training</td>
<td></td>
<td></td>
<td>Khani Gustafson</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The two-day core cultural-competence training is designed for all mental-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>health service providers; including administrators, clinicians, case managers,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>support staff, psychiatrists, psychologists, contractors, stakeholders, consumers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and family members. CONCEPTS: Awareness, understanding, knowledge, engagement,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>initial assessment, and cultural formulation.</td>
<td>14 Hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning Objectives: Because of this training, participant should be able to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>identify components of cultural identity, strengths, and values and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training Title</td>
<td>Description</td>
<td>Hours</td>
<td>Start Date</td>
<td>Facilitator</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------</td>
<td>--------------</td>
<td>----------------------</td>
<td></td>
</tr>
<tr>
<td><strong>WET -Mind, Body &amp; Spirit</strong></td>
<td>Simple breathing exercises to center the mind and prepare the mind for meditation; a guided visualization of light, spiritual reading and discussion.</td>
<td>14</td>
<td>03/24/2014</td>
<td>Gary Gibbs D.O.</td>
<td></td>
</tr>
<tr>
<td><strong>THRIVE: “Trauma-Informed” Theory to Application</strong></td>
<td>Impact of trauma on development and behavior. Protective and resiliency factors. Trauma-informed theory, principles, and practices. Elements of a trauma-informed agency or organization. Continuous quality improvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7 hours</td>
<td>68</td>
<td>8/19/2014</td>
<td>Arabella Perez, LCSW</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7 hours</td>
<td>73</td>
<td>8/20/2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Suicide Prevention and Outreach Training for Community Health Workers</strong></td>
<td>Move beyond common tendencies to miss, dismiss or avoid suicide. Identify people who have thoughts of suicide. Apply the TALK steps (Tell, Ask, Listen and Keep-Safe) to connect a person with thoughts of suicide to a suicide first-aid intervention caregiver. Become familiar with flipchart and materials developed by California Mental Health Services Authority to support the Spanish-speaking community in leaning about suicide prevention. Understand how personal and community beliefs and attitudes about suicide can affect suicide stigma and interventions. Identify and practice the basic elements to effectively facilitate a group presentation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7 Hours</td>
<td>16</td>
<td>5/5-6/2015</td>
<td>Scott Chavez</td>
<td></td>
</tr>
<tr>
<td><strong>Collaborative in South Bay</strong></td>
<td>Participants will be prepared to apply three strategies to market groups to the community and build group membership. Practice 1-3 methods of focusing and facilitating a behavioral health group. Learn ways to participate in the Greater Bay Area Mental Health and Education Collaborative to increase knowledge of EBPs in behavioral health and resources for behavioral health career development.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.5 hours</td>
<td>35</td>
<td>9/4/2015</td>
<td>Kristin L. Dempsey, MFT, LPCC</td>
<td></td>
</tr>
</tbody>
</table>
## 2017 Update: Monterey County Cultural Competence Plan Requirements

### California Department of Mental Health Cultural Competence Plan Requirements

| **Law & Ethics for Non-license-eligible & Administrative Staff** | New Legislation  
Confidentiality Basics  
Confidentiality / New MCHD Privacy Policies | 4 hours | 3/15/2016 | Linda J Garrett, JD |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>New Legislation, Consent for Minors and the Law, Confidentiality and New MCHD Privacy Policy, Mandated Reporting, Ethics: Dual Relationships, and Boundary Issues</td>
<td>6 hours</td>
<td>3/14/2016</td>
<td>Linda J Garrett, JD</td>
</tr>
<tr>
<td><strong>Law &amp; Ethics for Clinical Staff</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>New Legislation, Consent for Minors and the Law, Confidentiality and New MCHD Privacy Policy, Mandated Reporting, Ethics: Dual Relationships, and Boundary Issues</td>
<td>6 hours</td>
<td>3/14/2016</td>
<td>Linda J Garrett, JD</td>
</tr>
<tr>
<td><strong>LGBTQ Data Collection</strong></td>
<td>Attendees will learn to collect, quality check, and apply this data in a culturally sensitive and confidential manner. Participants will learn effective communication techniques, privacy and confidentiality, data quality, and addressing mistakes that inevitably occur</td>
<td>2 hours</td>
<td>11/9/2016 &amp; 11/10/2016</td>
<td>BHB Staff</td>
</tr>
<tr>
<td><strong>Providing Equal Access for Transgendered Population</strong></td>
<td>In this workshop attendees will explore the breadth of identities associated with trans and gender nonconforming communities, including the intersecting experiences of race, culture, socioeconomic circumstances, and health disparities. Participants will learn to utilize culturally competent language and behavior for addressing and working with this population, and increase their knowledge of health care access and legal issues that impact trans communities, within a substance use disorder and mental health context. Interactive, solutions-oriented, and engaging, this workshop will provide opportunities for learning and problem solving at all knowledge levels.</td>
<td>7 hours</td>
<td>1/11/2017</td>
<td>Willy Wilkinson &amp; Dr. Jennifer Hastings</td>
</tr>
</tbody>
</table>
III. RELEVANCE AND EFFECTIVENESS OF ALL CULTURAL COMPETENCE TRAININGS

A. Training Report on the relevance and effectiveness of all cultural competence trainings, including the following:

1. Rationale and need for the trainings: Describe how the training is relevant in addressing identified disparities;

In 2013 BHB commissioned two former county mental-health directors with strong cultural competence experience to assess the Bureau, including perceptions of the mental-health system in the community. A report was made, including recommendations regarding structure, governance, staffing, services and training. The report was developed in conjunction with the members of the CRHC, which at the time was known as the Cultural Competence Committee, and was utilized as a foundation for determining Cultural Competence Training opportunities.

Specialized training was provided to BHB staff, contractors, community providers, consumers, and family members on the complexities of incorporating cultural competency in the evaluation and assessment tools. BHB’s medical staff received specialized training on culturally responsive and sensitive treatment strategies to support and encourage appropriate, client-based services. A two-day Wellness and Recovery Conference in 2013 was held for consumers, family members and staff, with strong presentations and representation of cultural issues, including consumer-lived experience. These trainings were provided with the intent of enhancing participant’s understanding of the impact of culture and biases. Not focusing on any group, the trainings included a variety of vignettes, involving different cultural groups and learning activities about assumptions and differences in perception when the culture of an individual or family is not considered.

As stated throughout this report, it is critical for BHB staff to have a solid understanding of best cultural-competence practices due to our diverse populations’ needs. Having more knowledgeable and qualified staff as part of the BHB team will equip Monterey County’s mental-health system to address the disparities discussed in earlier portions of this plan. These skillsets will allow for expanded access, assist in the reduction of barriers and stigma, and help attract and retain the most vulnerable to receive services.

2. Results of Pre/Post Tests:

In 2013, training around cultural competence was developed and provided by Matthew Mock, PhD, former director of the CIMH Multi-Cultural Services Center, in collaboration with CIMH. The Cultural Competency Committee also was involved and, at the time, held face-to-face and telephone conferences with consultants and trainers to review and finalize the training plan. This included core foundation-training for staff, contractors, consumers, family members, collaborating government partners and community representatives, with 250 persons in attendance. Training evaluations reflected the following:
• 96% of licensed staff rated the sessions as good or excellent
• 90% of other participants reported the training expanded their awareness of diversity and culture, and its impact on health-seeking behavior, mental-health beliefs, attitudes and behaviors
• 94.1% reported the concepts and strategies are relevant to them

3. Summary of Evaluations:

Training evaluations reflected positive feedback, including high ratings for all trainings, and a self-reported increase in understanding that culture plays an important role in diverse communities. Although a pre-test was not conducted, we did experiment with two types of evaluations. The first format consisted of standard check-box ratings and brief comments. The second type of evaluation consisted of open-ended questions, calling for responses in narrative format. Specifically, what participants enjoyed learning about what was most useful in day-to-day operations and how strategies can be best applied to daily activities. Participants were encouraged to complete both evaluation formats. Both types of evaluations rated the trainings as very helpful, with much relevant learning content. Both evaluations rated the presenter as very knowledgeable and effective.

Open-ended evaluations resulted in richer content about what individuals gained. The narrative was thoughtful and linked the training experience to specific work-related tasks that promised an increase in the intent to integrate the training into work activities, such as treatment planning, assessment, team meetings, and more. The larger narrative evaluations, while rich in content, were more difficult to quantify and time consuming to assess. These evaluations demonstrated that cultural training, if done well, can have an impact on staff. Recognizing cultural diversity creates an emphasis on understanding the impact of multiple cultural factors, rather than a specific approach to one cultural group. It is the intention of the CHRC to develop a single evaluation instrument where participants can provide easily quantifiable responses and narrative context about what they learned and how it might be useful for them.

4. Provide a narrative of current efforts the county is taking to monitor advancing staff skills/post skills learned in trainings.

The CHRC will discuss how to monitor the integration of cultural knowledge and changes/improvements in engagement, assessment and retention at appropriate levels of care. The committee will review reports developed to monitor changes in access patterns, particularly for communities with identified disparities.

5. County methodology/protocol for following up and ensuring staff, over time and well after they complete the training, are utilizing the skills learned.

It is expected that if training is effective and integrated into service delivery, an increase will occur over time in access and retention of underrepresented communities. This information will be monitored by a review of reports from QI for the CHRC. The committee will monitor the proactive inclusion of cultural factors in various committee reports and activities of the Bureau and contractors.

In FY 16-17, BHB hired a new training coordinator, who will help keep track of relevant trainings and schedule required trainings for staff around cultural competence and other related topics. She
also will be responsible for disseminating pre- and post-training surveys to make sure trainings are effective and that the material covered is being used by staff.
IV. COUNTIES MUST HAVE A PROCESS FOR THE INCORPORATION OF CLIENT CULTURE TRAINING THROUGHOUT THE MENTAL HEALTH SYSTEM

A. Evidence of an annual training on Client Culture that includes a client’s personal experience inclusive of racial, ethnic, cultural, and linguistic communities. Topics for Client Culture training may include the following:

Sensitivity to cultural diversity and an awareness of Client Culture and resultant experiences is infused throughout BHB activities and practices. Contracted community programs are client led and help to inform the BHB and infuse a Client Culture throughout the system, such as the Recovery Task Force (RTF). RTF is led by a community based organization and ensures that 51% of meeting attendees, at any given time, are clients. This structure supports the client center culture, where clients can feel comfortable discussing gaps in the mental-health continuum and discuss innovative solutions to those issues. Their efforts help to improve services and programs for people with mental-health challenges, with the goals of increasing access, decreasing duplication, and facilitating community-wide support of mental-health recovery. Their meetings are attended by members of the BHB’s Quality Improvement (QI) team, Cultural Competency Coordinator and other BHB staff who seek to inform and improve the mental-health system by soliciting information and feedback about service access and program impact.

The OMNI Resource Center (Salinas) is another peer- and family member-run mental-health wellness center. It offers innovative healing, leadership and supportive programs, in a welcoming and inclusive environment. It promotes personal connection and mutual support. All staff and volunteers have a personal experience with mental-health issues and recovery, and believe recovery is possible for everyone. The goal of OMNI is to improve the quality of life and self-esteem of individuals with mental-health or emotional issues. It also empowers those in recovery to share their stories of success, so others can benefit from knowing there is help and a light at the end of what can be a very dark tunnel. Their experiences, successes, and challenges also work to inform the mental-health system.

B. The Training plan also must include, for children, adolescents, and transition-age youth, the parents’ and/or caretaker’s personal experiences with the following:

Dr. Jill Walker was hired in 2016 as the BHB’s Training manager, and plans to incorporate the following guiding principles of: Strength-Based, Trauma-Informed, Equitable, Culturally Responsive, Person Driven, Community Integrated, Evidence Supported, Outcomes Focused into future training opportunities.

Trainings will focus on these areas:

1. **Family Focused Services.** BHB values working with families as a primary mechanism of mental health support.
2. **Navigating Multiple Agency Services.** Developing good working relationships between programs (e.g., DSS, Probation, Courts), to support families impacted by these systems simultaneously (such as System Impacted Families)
3. **Recovery and Resiliency.** To better meet the needs of the community, MCBH is taking steps to become a wellness based organization. While individuals come to or are referred
to MCBH because of serious symptoms and/or impairments in life functioning is striving to focus on health and strategies to restore and/or improve health.

These guiding principles and areas of focus will inform the process and content of MCBH’s Clinical Training Plan. The Training Plan serves as a guide to keep staff development experiences focused on and accountable to these principles.
Rationale: The diversity of an organization’s staff is necessary, but not a sufficient condition for providing culturally and linguistically appropriate healthcare services. Although hiring diverse and bilingual individuals from different cultures does not in itself ensure that the staff is culturally competent and sensitive, this practice is a critical component to the delivery of relevant and effective services for all clients. Staff diversity at all levels of an organization can play an important role in considering the needs of clients from various cultural and linguistic backgrounds in the decisions and structures of the organization. (CLAS, Final Report).

I. RECRUITMENT, HIRING, AND RETENTION OF A MULTICULTURAL WORKFORCE FROM, OR EXPERIENCED WITH, THE IDENTIFIED UNSERVED AND UNDERSERVED POPULATIONS

Recruitment:

I. Advertise job opportunities in targeted foreign-language and minority health professional associations’ job boards, publications, and other media (e.g. social media networks, professional organizations’ email, etc.)

BHB actively advertises open recruitments. The Bureau works with the County Health Department’s HR to post job descriptions in various venues, including professional-association job boards and employment sites, as well as the County website. Job openings are shared internally with staff and with community-based partners and local universities to attract local talent.

II. Develop relationships with local schools, training programs, and faith-based organizations to expand recruitment base.

BHB has partnerships with local community-based organizations to expand recruitment and attract local talent. For the same purpose, BHB played a key role in the establishment of CSUMB’s MSW program. In its fifth year, the program has now graduated numerous qualified individuals, who possess the skillsets the Bureau needs to best serve the community’s diverse populations. In addition, several CSUMB Service Learning interns are placed within the department to complete their training hours and invest their developing skills, insights and commitment to the field in which they are working. Service Learners are intentional volunteers, who help the Bureau and other related local organizations further develop a workforce with the skillsets needed to adequately serve the residents of Monterey County.

III. Recruit at minority health fairs

BHB participates in job fairs, health fairs and community events relevant to the positions it is looking to fill, and communities it seeks to reach. An ancillary impact is that community members who attend these events have a chance to learn what BHB does and how it is engaged in serving the wider community.
IV. Collaborate with businesses, public school systems, and other stakeholders to build potential workforce capacities and recruit diverse staff. In particular, linkages between academic and service settings can help identify potential recruits already in the educational “pipeline” and provide them with additional academic support and resources necessary to meet job requirements (The Sullivan Commission on Diversity in the Healthcare Workforce, 2004).

BHB’s partnership with CSUMB has been instrumental in developing a local workforce of mental health providers. The Bureau, along with other community partners, works to incorporate regional community needs into the program’s curriculum. BHB staff participate through community advisory boards, field-placement subcommittees and resource-development subcommittees to assist in the development of the program. Staff also assists in the coordination of field placements for MSW students and bachelor-level students seeking to join the program.

V. Assess the language and communication proficiency of staff to determine fluency and appropriateness for serving as interpreters.

BHB strives to achieve language competence for the threshold language (Spanish). However, if program staff cannot meet the need for language assistance, then the program provides interpreter services. Policy 451, Cultural and Linguistic Services, establishes a process to provide free interpreter services for mental-health clients with limited English proficiency (LEP).

The Bureau is working diligently to comply by developing a process that ensures interpreters are trained and monitored for language capacity. Going forward, all interpreter contracts will include the following statements to ensure interpreters are trained and monitored for language competence:

- “Contractor shall ensure all personnel assigned to provide language-interpretive services meet all applicable licensing, certification, training and/or professional criteria during all periods of service provision. Interpreters shall demonstrate proficiency in English and non-English languages, possess knowledge of specialized terms used in the mental health field, and have clear understanding of interpreting ethics and practice.”
- “Contractor shall maintain files of language interpretation professional criteria of all assigned personnel, including contracted and subcontracted personnel. Contractor will maintain and make available personnel files of aforementioned professional criteria upon request of the County.”

Over the next two years, BHB will implement the following steps to ensure that all interpreters are screened and tested through the following process:

1) Preliminary screening through an over-the-phone interview to verify skills.
2) An oral proficiency test for both English and the target language. The exam will evaluate key areas, such as comprehension, grammar, breadth of vocabulary, pronunciation and enunciation, and overall presentation. If proficiency is advanced, the candidate will be scheduled for the next requisite test.
3) Interpreter Skills Assessment (ISA) is the Language Line Services proprietary test developed through more than 20 years’ experience. The ISA is a rigorous test
designed to evaluate a candidate’s interpretation skills. It is bi-directional, from English into a target language and from the target language to English. The ISA is evaluated by both an objective scoring method and a subjective assessment with an emphasis on the objective scores.

BHB also will develop an orientation process for interpreters and bilingual staff to ensure an understanding of the basics of interpretation ethics and confidentiality. Moreover, the Bureau will engage in research, via external experts, to ensure best practices for interpreter certification.

Promotion and Support:

I. Create a work environment that respects and accommodates the cultural diversity of the local workforce.

BHB and the Health Department are working to create an environment that respects, accommodates and celebrates cultural diversity. The yearly Latino Heritage and the Black History Month events both celebrate and teach culture. Events are organized by staff, who invite coworkers, clients and their family members, community advocates and other supporting partners to participate.

Yet this workforce culture of accepting, embracing and accommodating ethnic and cultural diversity goes beyond celebration. It is demonstrated in everyday language and vocabulary, privacy and inclusion, listening, deliberation and collaboration in daily practice.

II. Develop, maintain, and promote continuing education and career development opportunities so all staff members may progress within the organization.

BHB offers training opportunities for staff members, and supports continuous learning. Examples of such trainings include: Psychological Assessment Training, Law and Ethics for Non-Licensed staff and administrative staff. The Bureau’s up-to-date training calendar can be found at: http://qi.mtyhd.org/index.php/calendar-of-events/ County employees and BHB staff also are eligible to participate in county trainings, such as budgeting, time management, and conflict resolution, to name a few.

III. Cultivate relationships with organizations and institutions that offer health and human service career training to establish volunteer, work-study, and internship programs.

BHB has an established relationship with CSUMB to provide field placement opportunities for both Bachelors and Master of Social Work candidates. The field-placement program is called Service Learning, which is required at lower- and upper-division levels. This expansive program provides 70,000 volunteer/work-study hours per year in nonprofit organizations throughout the county. In addition, the university places students in field-study assignments and internships relative to their majors.

A. Extract a copy of the Mental Health Services Act (MHSA) workforce assessment submitted to DMH for the Workforce Education and Training (WET) component.
The MHSA Annual Update, for FY 2014-2015 can be found at: http://www.co.monterey.ca.us/home/showdocument?id=15391

The MHSA Annual Update for FY 2015-2016 can be found here: https://www.co.monterey.ca.us/Home/ShowDocument?id=26254

B. Compare the WET Plan assessment data with the general population, Medi-Cal population, and 200% of poverty data.

The threshold language for Monterey County is Spanish. In addition, other linguistic needs were identified, including the need to have Vietnamese and indigenous language translation for Mixteco and Triqui. Currently, the diversity in language proficiency in the public mental health workforce doesn’t represent our county’s needs.

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>County Population*</th>
<th>Medi-Cal Population**</th>
<th>200% under Poverty</th>
<th>Clients Served ***</th>
</tr>
</thead>
<tbody>
<tr>
<td>White Caucasian</td>
<td>135,763</td>
<td>11,993</td>
<td>57,121.80</td>
<td>2,132</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>239,901</td>
<td>103,755</td>
<td>55,223.69</td>
<td>4,605</td>
</tr>
<tr>
<td>Black/African American</td>
<td>10,907</td>
<td>1,935</td>
<td>1185.69</td>
<td>426</td>
</tr>
<tr>
<td>Asian; Pacific Islander</td>
<td>25,653</td>
<td>4,018</td>
<td>2,542.45</td>
<td>341</td>
</tr>
<tr>
<td>American Indian or Alaskan</td>
<td>1,251</td>
<td>134</td>
<td>No data collected</td>
<td>No data collected</td>
</tr>
<tr>
<td>Native Hawaiian; Pacific Islander</td>
<td>2,049</td>
<td>No data collected</td>
<td>No data collected</td>
<td>No data collected</td>
</tr>
<tr>
<td>Multi-Race/Other</td>
<td>9,403</td>
<td>11,891</td>
<td>1,734.55</td>
<td>1,108</td>
</tr>
</tbody>
</table>

*Source: 2010-2014 American Community Survey 5-year estimate  
** Source: EQRO’s 2015 – 2016 for Calendar Year 2014  

C. If applicable, the County shall report in the CCPR, the specific actions taken in response to the cultural consultant technical assistance recommendations as reported to the County during the review of their WET Plan submission to the State.
Monterey County contracted with a consultant to assist in the development of the WET Plan, which included a survey of workforce education and training needs. Based on the recommendations, BHB actively sought out training opportunities to provide cultural competence training to staff, and is committed to continuing to do so, even without state funding.

**D. Provide a summary of targets reached to grow a multicultural workforce in rolling out County WET planning and implementation efforts.**

The MHSA Update for FY 13-14 is the final year state-funded WET activities were included (see Appendix B, for more D-2 WET information). The following table includes a summary of the objectives outlined in Section D-2.

**Table 14: MHSA Update FY 13-14 WET Activities**

<table>
<thead>
<tr>
<th>Funding Category</th>
<th>Action Items</th>
<th>WET Strategies/Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce Staffing Support</td>
<td>Training, Targeted Recruitment</td>
<td>Coordinate training events for public mental-health system in partnership with the Southern Bay Area Workforce Collaborative. Provide up to ten (10) trainings per fiscal year on skill development areas, such as social rehabilitation, Medi-Cal billing, work expectations (i.e. how to receive feedback on work performance) and peer counseling. Topics will be developed by utilizing consumer and supervisor input.</td>
</tr>
<tr>
<td>Training &amp; Technical Assistance</td>
<td>Language Assistance</td>
<td>Ensure that translation and interpretation services are available whenever necessary.</td>
</tr>
<tr>
<td>Mental Health Career Pathways Programs</td>
<td>Inception of CSUMB’s MSW Program, Support for CSUMB’S Health and Human Services BA Program</td>
<td>Work in partnership with CSU Monterey Bay and other community partners to incorporate regional community needs into the MSW program.</td>
</tr>
<tr>
<td>Residency, Internship Programs</td>
<td>CSUMB Field Placement Interns (BA and MSW)</td>
<td>Coordinate field placements for current MSW students and bachelor-level students seeking to get into the program. Coordinate internships within the public mental-health system.</td>
</tr>
<tr>
<td>Financial Incentive</td>
<td>Scholarships, Loan Assumption Program, Bilingual Pay</td>
<td>Monitor implementation of scholarships for MSW students, Partner with Health Professions Education Foundation to increase applicants for the Mental Health Loan Assumption Program and the Licensed Mental Health Service Provider Education Program.</td>
</tr>
</tbody>
</table>
E. Share lessons learned on efforts in rolling out County WET planning and implementation efforts.

When the EMR system, Avatar, was being rolled out, there was a great deal of interest in training and preparing for its implementation and use. Staff were excited to be able to access data and share information, system wide. However, orientation required a great deal of service delivery and staff time. This had an impact on participation in various trainings and committees. The startup and monitoring for the EMR to ensure accuracy of data affected implementation of Cultural Formulation templates for staff to practice their training at work. Nonetheless, BHB continued to advocate for the incorporation and implementation of the Cultural Formulation templates to enhance service delivery.

The need for bilingual capacity in the system is recognized, and efforts to meet that need focus on minimizing duplication of work among bilingual staff, and facilitating usefulness for consumers who prefer their services and information in their own language. Language orientation is a challenging process, even for motivated staff since they also are required to meet the demands of large caseloads while completing required trainings.

F. Identify County Technical Assistance Needs

BHB could benefit from support in identifying effective models for language acquisition, plus assistance in utilization of EMR data to document impact of training on service delivery. Assistance with skill sets on best recruitment and retention practices for culturally competent employees to engage hard-to-reach populations would be helpful for the Bureau.
Rationale: Accurate and effective communication between clients, providers, staff, and administration is the most essential component of the mental-health encounter. Bilingual providers and other staff who communicate directly with clients must demonstrate a command of both English and the language of the client, which includes knowledge and facility with the terms and concepts relevant to the type of encounter (CLAS, Final Report). The DMH will provide threshold language data to each county.

1. INCREASE BILINGUAL WORKFORCE CAPACITY

A. Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity, including the following:

1. Evidence in the Workforce Education and Training (WET) Plan on building bilingual staff capacity to address language needs.

The partnership with CSUMB was established to help build capacity and assist in providing education and training to bilingual students, who could potentially become employees of BHB. The first cohort of MSW candidates graduated in Spring 2013. The intent of the MSW program is to ‘grow our own’ by providing the opportunity for Monterey County residents to pursue advanced education in social work without having to commute to neighboring counties or sacrifice fulltime employment. The program’s curriculum is focused on increasing student competence in serving the Hispanic/Latino community.

BHB and MCHD support CSUMB’s Collaborative Health and Human Services (CHHS) bachelor’s degree program, which offers concentrations in social work and community health. The program requires 240 field placement hours. Several bureaus within the Health Department, including BHB, and several of our community partners offer field-placement opportunities for these students.

The CRHC identified these partnerships as an opportunity given that many of BHB’s line staff have bilingual skills and currently serve the Hispanic/Latino Spanish-speaking community as case managers, behavioral health aides and support-group counselors. The CRHC recognizes that helping to build their capacity through education and training can help them become more competent providers and help the Bureau narrow the disparity gaps that currently exist.

2. Updates from Mental Health Services Act (MHSA), Community Service and Supports (CSS), or WET Plans on bilingual staff members who speak the languages of the target populations.

Students residing in Monterey County are applying, selected and completing the MSW program at CSUMB with the competencies needed to serve the diverse populations of Monterey County.
residents. A percentage of those graduating the program are of Latino/Hispanic descent and speak Spanish, giving them additional ability to relate to the most significant target population.

Because of the identified need for bilingual support services, the Bureau will continue to support the MSW and BA programs offered by CSUMB, while also seeking to develop other partnerships and training opportunities for current staff.

3. Total annual dedicated resource for interpreter services.

There is no set dollar amount allocated for interpretation services at this point. The Bureau procures what is needed as needs arise. For Vietnamese interpretation services, BHB contracts directly with Andy Nguyen. For all other languages, BHB engages a provider from the County’s master agreement list.

II. PROVIDE SERVICES TO PERSONS WHO HAVE LIMITED ENGLISH PROFICIENCY (LEP) BY USING INTERPRETER SERVICES.

A. Evidence of policies, procedures, and practices in place for meeting clients’ language needs, including the following:

1. A 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, shall be available for all individuals.

   **Note:** The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable.

   Policy 451 in Procedure: Part 7 (see Appendix D) mentions 24-hour service access to a toll-free line to assist staff and consumers with translation services. BHB clients can call 1-888-258-6029 at any time of the day. The call is answered by bilingual (English-Spanish) Access Team staff. Calls are centrally answered and may be forwarded to the nearest regional office if the caller is requesting services in their area.

   After business hours and on holidays, calls to the toll-fee line are routed to an answering service with bilingual capacity. If the call is urgent, or the caller needs to speak to someone immediately, the call is linked to the Crisis Team staff at Natividad Medical Center (NMC). If the caller needs information about other available services in the community, the caller is provided the 211 number and forwarded. If the caller desires to leave a message, the answering service takes the message and forwards the call to the Access Team the next business day.

   The answering service has bilingual (English-Spanish) capacity and access to the AT&T Language line. Community providers and the telephone information operator generally provide the number to the Crisis Team if a caller is requesting an emergency mental health number.
2. Least preferable are language lines. Consider use of new technologies such as video language conferencing. Use new technology capacity to grow language access.

Currently the Bureau contracts directly with Andy Nguyen, a licensed translator /interpreter contracted for Vietnamese interpretation services. For other languages BHB engages a provider from the County’s master agreement list, when needed. In the future, BHB will consider the use of new technologies to support these efforts.

3. Description of protocol used for implementing language access through the County’s 24-hour phone line with statewide toll-free access.

During normal working hours, BHB clinics are available by calling 1-888-258-6029. Since Monterey County’s threshold language is Spanish, the calls are answered by bilingual (English-Spanish) Access Team staff. Calls are centrally answered and may be forwarded to the nearest regional office if the caller is requesting services in their area.

BHB strives to have bilingual and bicultural staff in every service area. If a client comes in at a time when a member of the bilingual staff is not on site or is unavailable, the staff on site can request the assistance of Language Line, through which necessary services can be identified. Staff is provided with Language Line instruction cards containing a BHB identification number and instructions on process.

Language Line will provide the appropriate interpreter within a reasonable amount of time. The interpreter will help staff explain the interpretation process to the individual/family and ensure them of confidentiality. If the caller’s language is undetermined, staff will contact Language Line for assistance in determining the language and attempt to obtain the caller’s telephone number to ensure follow up if they are inadvertently cut off before obtaining an interpreter. Directions can be found in the clinical documentation guide (including policies and expectations of all BH staff), which is available on the BHB QI website on page 101: http://qi.mtyhd.org/wp-content/uploads/2014/09/Documentation-Guide-2017-03-31.pdf

Once again, during after business hours and on holidays, calls to this line are routed to an answering service with bilingual capacity. If the call is urgent, or the caller needs to speak to someone immediately, the call is linked to the Crisis Team staff at Natividad Medical Center (NMC). If the caller needs information about other available services in the community, the caller is provided the 211 number and forwarded. If the caller desires to leave a message the answering service takes the message, informs the caller about the clinics hours and forwards the message to the Access Team the next work-day morning within half an hour of the clinic’s opening. The answering service has bilingual (English/Spanish) capacity and access to the AT&T Language line.

Family members should be used only to obtain sufficient information to arrange for the appropriate interpreter. We have information on interpreter services on our QI website: http://qi.mtyhd.org/index.php/special-topics/interpreting-services/. Clients will be assured that interpretation services are provided at no cost to them and that efforts will be made to provide services in their preferred language to the extent that resources are available.
4. Training for staff who may need to access the 24-hour phone line with statewide toll-free access so as to meet the client’s linguistic capability.

During orientation, staff who need access to the 24-hour line are provided information about interpretation resources and Language Line. Each employee receives a card provided by Language Line with instructions on calling and obtaining the appropriate interpreter.

B. Evidence that clients are informed in writing in their primary language, of their rights to language-assistance services. Including posting of this right.

Consumers are informed of their rights to services in their preferred language, and their preference is recorded in the Electronic Medical Record (EMR) during initial assessments. Materials informing clients of the availability of interpretation services at no cost to them are provided during the initial visit. Every effort is made to provide services by bilingual staff directly, without use of an interpreter, but the client is still informed of the availability of interpretation services. Each Access Team has bilingual staff (English-Spanish) and materials in both languages. Additional language information about interpretation is available through materials provided by the Language Line. Posters and cards with information about interpretation services are displayed throughout the offices, so clients have access to information in their preferred language.

C. Evidence that the county/agency accommodates persons who have LEP by using bilingual staff or interpreter services.

Use of interpreters is documented in the EMR, and the consumer’s preference for services in their own language is noted in admission documents. Interpretation services provided by others are noted in billing invoices from contracted interpreters, including date, name, location and amount of time.

1. Share lessons learned around providing accommodation to persons who have LEP and have needed interpreter services or who use bilingual staff.

Various levels of staff have used Language Line services over the years, including psychiatrists. Although the availability of bilingual staff is preferable to Language Line use, it is considered helpful until in-person resources can be identified to provide services in the individual’s preferred language.

The following lessons have been learned about providing services to persons with LEP:

- It is helpful to have a pre- and a post session with the interpreter.
- It is important to train clinicians on how to utilize interpreters.
- It is beneficial to train interpreters about mental health services provided in our County.
- It is essential to have professional interpreters, rather than a family member translate. Translators should be neutral and someone the client doesn’t know.
- More bilingual staff are needed. BHB supports County human resource efforts to increase bilingual staff.
D. Share historical challenges on efforts made on the items A, B, and C above. Share lessons learned.

BHB is committed to providing services in the client’s preferred language; however, bi-lingual personnel qualified to provide such services are scarce. Historically, this has been one of the reasons BHB has partnered with all the community organizations mentioned throughout this plan; to best meet the needs of the diverse populations it serves. Conflicting priorities and budget impacts make it difficult to dedicate adequate funds to provide high-level interpreter services in a diversity of languages. Nonetheless, the Bureau understands local linguistic barriers and is working to address these in the best way possible.

E. Identify County technical assistance needs.

The Bureau sees a need for technical assistance to most effectively identify languages spoken by callers, especially those who speak languages infrequently encountered in this County. Technical assistance also is needed to improve outreach to clients with Limited English proficiency. It would be useful to receive training and implement strategies that go beyond language barriers to help engage clients who have low utilization rates of service.

III. PROVIDE BILINGUAL STAFF AND/OR INTERPRETERS FOR THE THRESHOLD LANGUAGES AT ALL POINTS OF CONTACT.

A. Evidence of availability of interpreter (e.g. posters/bulletins) and/or bilingual staff for the languages spoken by community.

Although BHB prefers bilingual staff available to serve clients, Language Line information is always available. Posters and cards with information about interpretation services are also displayed throughout the offices so that clients have information in their preferred language. If bilingual staff are not present or available at the office when a client with language needs comes in, staff members always can contact Language Line for assistance. Clinics have bilingual (English-Spanish) support staff on site at each location. The Crisis Team staff at NMC Emergency Department have available interpreters for Hispanic/Latino and Filipino clients and family members. Other languages are available through NMC’s interpretation services as well as Language Line.

B. Documented evidence that interpreter services are offered and provided to clients and the response to the offer is recorded.

EMR documents, including Assessments and Services Plans, indicate the clients’ preferred language. An acknowledgement of interpretation services is provided, and client response is recorded for requested interpretation services. The Consumer Handbook also provides information about availability of interpretation services, at no cost.
C. Evidence of providing contract or agency staff that are linguistically proficient in threshold languages during regular day operating hours.

Each contractor is requested to review and sign a Cultural Competence Exhibit as part of their contract. The exhibit clearly identifies the need to provide availability of services in English and Spanish, and other languages as necessary during regular operating hours. The scope of work also includes expectation that services will be provided in the consumer’s preferred language. Contract Monitors are expected to manage availability of signage and services.

D. Evidence that counties have a process in place to ensure that interpreters are trained and monitored for language competence (e.g., formal testing).

All bilingual staff is tested for language proficiency upon hire. Interviews of bilingual applicants generally include a Spanish-speaking conversation with bilingual staff to assess fluency. Bilingual staff are utilized to provide interpretation services when needed. Staff using these interpreters also are required to participate in training, so they understand the process. Additional training is being planned once funds are made available.

IV. PROVIDE SERVICES TO ALL LEP CLIENTS NOT MEETING THE THRESHOLD LANGUAGE CRITERIA WHO ENCOUNTER THE MENTAL HEALTH SYSTEM AT ALL POINTS OF CONTACT.

A. Policies, procedures, and practices the county uses that include the capability to refer, and otherwise link, clients who do not meet the threshold language criteria (e.g., LEP clients) who encounter the mental health system at all key points of contact, to culturally and linguistically appropriate services.

The Access to Treatment design includes utilization of community services if the client needs services other than what is provided by BHB. Access Team staff meet with the client to determine needs and may provide assessment, short-term group services, referral to ongoing services, referrals to contractor-provided services, or community services, which the client agrees are appropriate for their needs. Ongoing services are offered to Medi-Cal beneficiaries who meet the Medi-Cal Necessity Criteria. See below for the Images of the Access to Treatment cards used by BHB. They also can be found in Appendix C.
B. Provide a written plan for how clients who do not meet the threshold language criteria, are assisted to secure, or linked to culturally and linguistically appropriate services.

Clients can obtain appropriate services, either directly through BHB clinics or community providers. The client can make the initial call, and he or she will be asked a few questions, including if they
have Medi-Cal. Then they will be transferred to the regional office closest to them. If they don’t meet the threshold-language criteria, a BHB staff member will work to identify their needs and connect them to the appropriate community resource. After hours, on weekends and holidays, calls are answered by a local answering service with access to interpretation services. They will connect callers to the Crisis Team at Natividad Medical Center if needed; otherwise they will take a message, and a BHB staff member will return their call on the next business day.

C. Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 (see page 32) requirements:

1. Prohibiting staff from expecting family members to provide interpreter services;
2. A client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services
3. Minor children should not be used as interpreters.

Policy 451Cultural and Linguistic Services states:

“...staff is prohibited from expecting family members and friends to provide translation. Only in unplanned situations will clinical staff utilize clerical staff for interpretation and translation services unless the consumer prefers a family member or friend to do the translation.”

To ensure accurate translation, BHB staff is prohibited from using family members and friends to provide translation services, as well as clerical staff, except in unplanned circumstances. When possible, Monterey County BHB will assign staff who speak the same language as the client. Consumers also may request a provider who is of their same ethnic background or whom they feel can best understand their culture. Similar efforts will be offered regarding contractual providers. Written material will be provided to the consumer in font size 14 (or larger upon request).

If needed, an audio tape of the materials is provided and is available to consumers on this webpage: http://qi.mtyhd.org/index.php/home/printable-documents/ Click on “Medi-Cal Guide to Mental Health Services” to access the audio version. Policy 451 is attached to this document and noted in Appendix D for review.

V. REQUIRED TRANSLATED DOCUMENTS, FORMS, SIGNAGE, AND CLIENT INFORMING MATERIAL.

A. Culturally and linguistically appropriate written information for threshold languages, including the following, at minimum:

Policy 452 Distribution of Translated Materials states:

“...Materials providing information for consumers will be available in a language that is understandable to the language-threshold population. Materials that require translation will be reviewed by several persons, including the program supervisor and management staff prior to distribution. All materials will be available at service locations, and program management staff will be responsible to ensure a sufficient quantity is available at each location. General information
regarding health and mental-health will be available in the waiting areas of the service programs.

Policy 452 can be found in Appendix E for review.

B. Documented evidence in the clinical chart that clinical findings/reports are communicated in the clients’ preferred language.

The EMR documentation includes client’s language of preference and documents provided in the client’s preferred language.

C. Consumer satisfaction survey translated in threshold languages, including a summary report of the results (e.g., back translation and culturally appropriate field testing).

BHB utilizes the state’s satisfaction survey instruments to gather information from clients and family members about their level of satisfaction and benefit from participation in services. Surveys are provided in the consumer’s language of preference. Reports are developed by the department for distribution.

D. Mechanism for ensuring accuracy of translated materials in terms of both language and culture (e.g., back translation and culturally appropriate field testing).

Materials are translated by a contractor and are reviewed by bilingual staff for accuracy. Some materials also are reviewed by the CRHC to ensure appropriate use of language and content. Recommendations from the CRHC are incorporated into final materials.

E. Mechanism for ensuring translated materials is at an appropriate reading level (6th grade).

Source: Department of Health Services and Managed Risk Medical Insurance Boards.

Translated materials also are reviewed by staff and Family Partners for content and clarity before finalization. The CRHC also provides feedback on reading level of materials and presentations. Promotores trainers occasionally are asked to have their staff review and give feedback on translated materials.
Rationale: Organizations should ensure that clients/consumers receive from all staff members, effective, understandable, and respectful care, provided in a manner compatible with their cultural health beliefs and practices and preferred language (CLAS Final Report).

I. CLIENT DRIVEN/OPERATED RECOVERY AND WELLNESS PROGRAMS.

A. List and describe the County’s/Agency’s client-driven/operated recovery and wellness programs.

Adult Wellness Center/OMNI Resource Center (Interim, Inc.)

The OMNI Resource Center provides outreach, prevention education, and peer support, which contribute to improvements in personal functioning through the development of social and independent living skills. Services are delivered by paid consumers and volunteer staff, in English and Spanish, with administrative oversight from a nonprofit mental-health services organization (Interim, Inc.). All services are provided at no cost. The center is open Monday through Friday, 10am to 4pm, and provides after hours services for adults, ages 18-30, on Mondays and Wednesdays, from 4pm to 6pm. Services include an assortment of activities, including wellness and recovery services, relapse prevention, healthy boundaries, whole health, and “No Estás Solo” (You are not Alone) support groups. For more information, please visit http://www.interiminc.org/

Epicenter

Epicenter is Monterey County’s first youth-led community center. The center provides resources and counseling for youth, ages 16-24, especially those who are transitioning out of foster care. Services include information, referral and linkage, coaching and mentoring, training, healthy eating and lifestyle education, outreach and relationship building with system partners, development and sustainability of local volunteers, and development, partnership, and support around various LEP-related special events and experiences, emphasizing employment and education opportunities. It also offers support and empowerment services for LGBTQ youth. Because of the PEI planning process, PEI funds are utilized to support these services. See pages 42-43 of the Behavioral Health Strategic Plan (Appendix F) for more information, or visit their website at http://www.epicentermonterey.org/.

Additional Programs

Other client-driven wellness programs are set up to accommodate cultural and linguistic preferences include: Promotores de Salúd, National Alliance on Mental Illness (NAMI) Connections, and the Recovery Task Force. See Criteria 3, Section III A, Pg. 38 for more information on these.
1. **Evidence the county has alternatives and options available within the above programs that accommodate individual preference and racially, ethnically, culturally, and linguistically diverse differences.**

Omni Resource Center services are offered by ethnically diverse staff who understand and celebrate cultural diversity. The services provided at the Omni Center are based on personal connection and self-determination, therefore ensuring each client may experience services that are suitable for their individual preferences. A few of the most integral values of the Omni Center are to value the diversity of the staff, designing services that are meant to meet the diverse cultures of the clients, and to keep the focus on the whole person. The Epicenter is an innovative type of organization that is run by youth that again is focused on personal connection. Based on the desires of youth in the area services are provided with a positive lens rather than a problems orientation.

2. **Briefly describe, from the list in ‘A’, those client-driven/operated programs that are racially, ethnically, culturally, and linguistically specific.**

The Omni Resource Center, Epicenter, Promotores de Salud and NAMI are all client-driven and focused on sharing one’s experiences to help each other. All staff and volunteers at the Omni Center have personal experience with mental health issues and recovery. The Promotores program trains community members to provide health knowledge to other members of their community and connect them to local resources they can use. The Epicenter was founded by youth and continues to be run by youth in partnership with many other community resources, thus being client driven from the very start.

### II. RESPONSIVENESS OF MENTAL HEALTH SERVICES

**A. Documented evidence that the County/contractor has available, as appropriate, alternatives and options that accommodate individual preference, or cultural and linguistic preferences, demonstrated by the provision of culture-specific programs, provided by the County/contractor and/or referral to community-based, culturally-appropriate, non-traditional mental health provider.**

BHB provides opportunities for participation in services consistent with client’s interests and needs. Services for Alternative Medicine are available for consumers and family members. Everyone is invited to attend a presentation on Alternative Healing Practices, provided by a staff psychiatrist.

The Village Project is a program that provides professional-development services, thereby increasing the availability of culturally competent services for the African American community. The work includes cultural-competence development and systematic-outreach activities. The Village Project also provides individual and family counseling, parenting groups, and other prevention services. These services are available to all ages and for Medi-Cal beneficiaries.

Additionally, Promotores programs offer early psycho-educational services, limited individual/family services, and provide referrals for more specialized services in BHB. The Promotores (visit [http://cca-viva.org/health/](http://cca-viva.org/health/)) utilize an evidence-based approach in their outreach.
into the community. Promotores provide a bridge to services for the uninsured Latino Immigrant community, by readily communicating in the threshold language of Spanish. Specialized short-term mental-health services are available for individuals and families in need. Additional resources have been allocated to this project to augment the psychiatric support available to service participants.

Counseling and Therapy Services (C.A.T.S.) provides a supportive space in which individuals and their families can talk confidentially with an LGBT-friendly staff and LGBT-identified professionals. C.A.T.S. provides the HIV/AIDS and LGBT communities in Monterey County with priority services for individuals and groups. Services are available for persons with Medi-Cal and those who are uninsured. The program conducts outreach and is available to all Monterey County residents, with services available in English and Spanish. For more information, please visit http://www.chservices.org/mental-health/c-a-t-s/

The OMNI Resource Center is available to Monterey County residents. Outreach into various communities is done by consumers and family members. Self-help, wellness and recovery activities and services are available at no cost to interested adults. Outreach services and specialized groups and activities are available for Spanish-speaking adults. OMNI Center staff conducts additional groups and activities for the Spanish-speaking community on Wednesday and Friday nights in East Salinas.

B. Evidence that the County informs clients of the availability of the above listing in their member services brochure. If it is not already in the member services brochure, the County will include it in their next printing or within one year of the submission of their CCPR.

Information about each program is available in each office and in community announcements about BHB services. Brochures for each program are also advertised throughout the BHB system and offered as resources by staff.

C. Counties have policies, procedures, and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services. (Outreach requirements as per Section 1810.310, 1A and 2B, Title 9)

PEI activities include regular and ongoing participation in community-health fairs, presentations, workshops and trainings to increase awareness about mental-health services. PEI staff provide support to reduce the stigma associated with mental health, and celebrate recovery and resiliency. The PEI coordinator conducts special outreach at community events, churches, schools and community centers, and distributes materials and information about BHB programs and partner organizations to underserved and unserved consumers, family members and community residents. Marketing materials include Each Mind Matters and Know the Signs materials, and brochures with contact information for additional assistance in locating and receiving care. The PEI coordinator also participates in bilingual radio talk shows, TV interviews, community coalitions, and agency committees.
D. Evidence that the County has assessed factors and developed plans to facilitate the ease with which culturally and linguistically diverse populations can obtain services. Such factors should include:

1). Location, transportation, hours of operation, or other relevant areas;

BHB services have been organized into three (3) regions. Regions provide walk-in clinics, short-term groups, and access to additional services as needed. All clinics have bilingual capacity and access to the Language Line, as stated in Criteria 7, Section II, A. Clients can call 1-888-258-6029 and request services in their preferred language at no cost. Contract interpreters are available if regional offices do not have someone who can speak a language. Regional clinics serve all ages and provide case management assistance for locating other available community resources if necessary.

System Navigators, who are familiar with all the services, provide support to consumers and family members if needed. The Access to Treatment model has been implemented system wide to provide access to available resources to Medi-Cal beneficiaries and others. Hours of operation are generally 8am to 5pm, but some regional offices have additional hours as needed.

2). Adapting physical facilities to be accessible to disabled persons, while being comfortable and inviting to persons of diverse cultural backgrounds (e.g., posters, magazines, décor, signs); and

Regional offices are accessible for persons with disabilities and have materials available for diverse communities. Signage is in English and Spanish, but all clinics have access to additional language assistance. Most recently, sites are assessing the cultural relevance of the physical space and are identifying ways in which to further create an inviting environment for the diverse population they serve.

3). Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and /or partnerships, such as primary care and in community settings. (The County may include evidence of a study or analysis of the above factors, or evidence that the County program is adjusted based upon the findings of their study or analysis.)

BHB regional offices are located at a local community-hospital campus, a courthouse, public health office, central community business area, and co-located with community health clinics. In addition, many services, particularly those offered by the Children’s Division, go to community locations to render services. These locations frequently include schools and community-resource centers.

III. QUALITY OF CARE: CONTRACT PROVIDERS
A. Evidence of how a contractor’s ability to provide culturally competent mental health services is taken into account in the selection of contract providers, including the identification of any cultural language competence conditions in contracts with mental health providers.

All requests for proposals include language which explains that services are to be available to the diverse community. Contracts contain Exhibit E, which specifically identifies needs and goals of cultural competency, requirements for availability of services, and materials in the threshold language (Spanish), and staff cultural-competence training requirements. Each contract specifies that organizations must have a written cultural competence plan or policy, and that all services are available to the community served by BHB.

IV. QUALITY ASSURANCE

A. List if applicable, any outcome measures, identification, and descriptions of any culturally relevant consumer outcome measures used by the County.

The Quality Improvement Workplan for 2017-2018 outlines specific measures to increase cultural and linguistic services (Please see Appendix J for the entire report). The goals are:

- To Improve cultural humility and sensitivity within service delivery system for mental health and substance use disorder services, and

- To Improve health equity in the Latino population

These goals are like those identified in the CCAP, in 2018 the Cultural Competency Coordinator will work closely with QI to support actions that will increase cultural and linguistic actions and measures that are in alignment with both plans and improve cultural and linguistic services. Copies of both plans can be found in the Appendix G and J.

B. Staff Satisfaction: A description of methods, if any, used to measure staff experience or opinion regarding the organization’s ability to value cultural diversity in its workforce and culturally and linguistically competent services; and

As part of the CCAP, BHB staff were interviewed and invited to participate in a focus group. BHB staff from various branches and in various capacities. Staff participants included staff from Quality Improvement, MSHA programming, and BHB training and development. Staff maintained a continuous presence at the Cultural Relevancy and Humility Committee and subcommittee meetings, they supported focus group recruitment efforts, participated in formal and non-formal conversations about cultural competency and were included in focus groups and in a key informant interview.

The BHB’s focus group had a total of 19 participants: three Case Coordinators, five Supervisors, one Support Staff Supervisor, six Managers, two Deputy Directors, one Program Administrator, and one Social Worker III. They were asked a series of questions (see Exhibit - that led to a rich discussion about their definitions of equality versus equity, barriers and solutions to providing culturally relevant services, challenges and solutions for supervising a diverse group of employees, and how to best
welcome a diverse community. Below are highlights on some important points staff raised and shared during the session.

The group made an earnest effort to work through defining and contrasting equality and equity. As the group worked through these concepts, they began to tease out some of the underlying complexities that providers and clients face in achieving culturally appropriate (possibly equitable) services. Notably, the group identified many of the same barriers and solutions that were raised in the client focus groups. These parallels show the potential for greater alignment within the client/practitioner relationships. Staff took the opportunity to articulate their own personal biases that, in addition to systemic and institutional attitudes and practices, reinforce the issues that get in the way of serving a culturally and racially diverse population.

In practice, staff recognized the need to develop more trust with communities and to demonstrate their desire to reconcile the issues raised by both groups. BH staff understood the need to connect more with the community as a way of learning and to move toward a culturally relevant practice. Other issues they identified (from a longer list) include: being more open, hiring staff with shared lived experiences, and creating a safer space to share fears and concerns. Staff at the focus group recognized that this work needs to be done, and that it is an ongoing process—one that requires continuous learning and asking hard questions about how to be more culturally relevant. The focus group conversation showed a strong understanding and desire to more intentionally build a perspective of equity within their own practices and within each level of the bureau.

BHB could explore focus groups for staff to share their experiences and/or opinion regarding cultural diversity in the organization and administer an annual staff satisfaction survey.

C. Grievances and Complaints: Provide a description of how the county mental health process for Medi-Cal and non-Medi-Cal client Grievance and Complaint/Issues Resolution Process data is analyzed and any comparison rates between the general beneficiary population and ethnic beneficiaries.

Policy 128 Posting of Grievance Process Procedure provides a clear description of BHB’s Client Problem Resolution Process. Any person who receives mental-health services can file a grievance. To do so, consumers may write, call or contact in person, Monterey County Behavioral Health Quality Improvement. Consumers will receive written receipt of the grievance and will receive a decision within 60 calendar days from the date filed. This policy can be found on the following link: http://qi.mtyhd.org/wp-content/uploads/2014/09/128-Beneficiary-Problem-Resolution-Process-Grievance-Standard-Appeals-Expedited-Appeals.pdf.
APPENDICES

Appendix A: Exhibit E .................................................................................................................. 104
Appendix B: MHSA FY 2013-14 through 2016-17 Section D-2 WET ........................................ 108
Appendix C: Access to Treatment Cards .................................................................................... 115
Appendix D: Policy 451 .............................................................................................................. 116
Appendix E: Policy 452 ............................................................................................................... 118
Appendix F: Behavioral Health Mental Health Services Act FY18-20 ................................. 120
Appendix G: Cultural Relevancy and Humility Committee (CRHC) Action Plan .............. 330
Appendix H: Behavioral Health Adult and Children’s Services: System of Care Brochure 380
Appendix I: Quality Improvement Workplan Fiscal Year 2017/2018 ................................. 388
Appendix J: MHSA Program Evaluation Structure ................................................................. 402
EXHIBIT E: 
ASSURANCE OF COMPLIANCE WITH 
MONTEREY COUNTY CULTURAL COMPETENCY POLICY 

Behavioral Health Bureau 

The Department of Health Care Services - Mental Health Services Division, mandates counties to develop and implement a Cultural Competency Plan. This applies to all Behavioral Health Bureau (BHB) services. Policies and procedures, and all services must be culturally and linguistically appropriate. Agreement agencies will be included in the implementation process of the most recent state-approved cultural competency plan for the County of Monterey and shall adhere to all cultural competency standards and requirements.

In a culturally relevant and resilient system, each provider organization shows respect for and responds to individual differences and special needs. Services are provided in the appropriate cultural context and without discrimination related to race, national origin, socioeconomic status, religion, gender, sexual orientation, age, language preference, literacy level, or physical disability. Culturally competent providers are aware of the impact of their own culture on their relationships with consumers/families and know about and respect cultural and ethnic differences. Cultural competence is a developmental and dynamic process – one that occurs over time.

Organizations in a Culturally Competent Service System Promote:

Quality Improvement

- Continuous evaluation and quality improvement
- Supporting evidence-based, promising, community defined, and emerging practices, congruent with ethnic/racial/linguistic group belief systems, cultural values and help-seeking behaviors.

Collaboration

- Collaborating with Behavioral Health and other community programs
- Resolving barriers to partnerships with other service providers

Access

- Providing new services to unserved and underserved children, youth, adults and/or older adults
- Reducing disparities in access to, and retention in care as identified in the Mental Health Services Act Plan
• Ensuring representation of mental-health services consumers and family members, and/or representatives from unserved communities on their advisory/governance body or committee for development of service delivery and evaluation (with a minimum target of 40%)
• Developing recruitment, hiring, and retention plans reflective of the population focus, communities’ ethnic, racial, and linguistic populations.

**Culturally Competent Services:**

• Are available, accessible and welcoming to all clients, regardless of race, ethnicity, language, age, and sexual orientation.
• Provide a physical environment that is friendly, respectful and inclusive of all cultures.
• Provide information, resources and reading materials in multilingual formats.
• Promote and develop culturally appropriate social interactions, respect and healthy behaviors within the family constellation and service delivery system.
• Provide options for services, which are consistent with the client’s beliefs, values, healing traditions, including individual preferences for alternative, spiritual and/or holistic approaches to health.
• Offer services in unserved and underserved communities.
• Have services available in the evening and on weekends to ensure maximum accessibility.
• Offer services in the identified threshold languages of English and Spanish, and other languages (Tagalog, Vietnamese, Mixtec, Triqui and other languages, as appropriate), spoken by Monterey County residents.

**Definitions for Cultural Competency**

“Cultural Competence” is defined as a set of congruent practice skills, knowledge, behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family members, and professionals that enables that system, agency, or those professionals and consumers, and family member providers to work effectively in cross-cultural situations. (Adapted from Cross, et al., 1989; cited in DMH Information Notice No.02-03).

“Cultural Competence” is a means to eliminating cultural, racial and ethnic disparities. Cultural Competence enhances the ability of the whole system to incorporate the languages, cultures, beliefs and practices of its clients into the service. In this way, all clients benefit from services that address their needs from the foundation of their own culture. Strategies for elimination of these disparities must be developed and implemented. Cultural Competence must be supported at all levels of the system.

(CMHDA Framework for Eliminating Cultural, Linguistic, Racial and Ethnic Behavioral Health Disparities)

{Cultural Competency} A set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and consumers and enables that system, agency or those professionals and consumers to work effectively in cross-cultural situations.
The ability to work effectively with culturally diverse clients and communities.

(Randall David, 1994)

CONTRACTOR hereby agrees that it will comply with the principles and guidelines set forth in Monterey County Health Department – Behavioral Health Cultural Competency Policy (as outlined above), and shall:

1. Develop organizational capacity to provide services in a culturally and linguistically competent manner. This may include hiring staff with the linguistic capabilities needed to meet the diverse language needs of Monterey County (Spanish, Tagalog, Vietnamese, Mixteco, Triqui, American Sign Language (ASL), Middle Eastern languages); providing staff with training in cultural competence; making services accessible at locations and times that minimize access barriers, and ensuring that staff have an open, welcoming and positive attitude and feel comfortable working with diverse cultures.

2. Create a physical environment that ensures people of all cultures, ages and sexual orientation feel welcome and cared for. This includes decorating waiting and treatment areas with pictures that reflect the diverse cultures of Monterey County, providing reading materials, resources and magazines in varied languages, at appropriate reading levels and suitable for different age groups, including children and youth; consideration of cultural differences and preferences when offering refreshments; ensuring that pictures, symbols or materials on display are not unintentionally disrespectful to another culture.

3. Provide a services delivery environment that ensures people of all cultures, ages and sexual orientation feel welcome and cared for. This includes respect for individual preferences for alternative, spiritual and/or holistic approaches to health; a reception staff competent in the different languages spoken by consumers/families; staff knowledgeable of cultural and ethnic differences and needs, and able and willing to respond an appropriate and respectful manner.

4. Support the county’s goal to reduce disparities to care by increasing access and retention, while eliminating barriers to services by underserved and underserved communities.

5. Include the voice of multi-cultural youth, client and family members, including monolingual and bilingual clients, and family members and representatives from unserved and underserved communities, in the advisory/governance body or committee for development of service delivery, planning and evaluation (County Goal: 40%).

6. Participate in outcome evaluation activities aimed at assessing individual organizations, as well as countywide cultural competency in providing mental health services.

7. As requested, meet with the Monterey County Health Department - Behavioral Health Director and Ethnic Services Manager annually to monitor progress and outcomes of the project.

8. Ensure that 100% of staff, over a three-year period, participate in cultural competency training including, but not limited to, those offered by Monterey County Behavioral Health.
Dissemination of these Provisions. CONTRACTOR shall inform all its officers, employees, agents, and subcontractors providing services hereunder of these provisions.

To assist the Contractor’s efforts toward cultural and linguistic competence, BHB shall provide the following:

1. Technical assistance to the Contractor(s) regarding cultural competence implementation.
2. Demographic information to the Contractor(s) on service areas for services planning.
3. Appropriate cultural competence measurement tools to help guide project outcomes.

By my signature below, as the authorized representative of the CONTRACTOR named below, I certify acceptance and understanding for myself and the CONTRACTOR of the above provisions.

________________________________________
Contractor (Organization Name)

________________________________________
Signature of Authorized Representative

________________________________________
Name of Authorized Representative (printed)

________________________________________
Date
APPENDIX B

2013/14 ANNUAL UPDATE
WORKFORCE EDUCATION AND TRAINING

County: Monterey

PROGRAM DESCRIPTION FOR FY 2013-14

A. Workforce Education & Training (WE&T) Coordination

Objectives:
1. Coordinate training events for public mental health system in partnership with the Southern Bay Area Workforce Collaborative.
2. Complete and monitor contracts with entities providing workforce education and training programs and services.
3. Participate in and support regional and state education and training efforts to ensure coordination and reduce duplication of services.
4. Participate in local initiatives which expand opportunities and fiscal support for workforce development, i.e. community colleges.
5. Provide annual updates to WE&T plan and evaluate effectiveness of services and trainings provided.
6. Update webpage to coordinate and provide training information.
7. Convene WE&T Work Group meetings to provide implementation and evaluation updates.
8. Coordinate internships within the public mental health system.
9. Ensure that translation and interpretation services are available whenever necessary.
10. Ensure that evaluation is embedded into every contract, program, and training event.
11. Ensure the social marketing strategies are incorporated in activities, as appropriate.
12. Collaborate with high schools to reduce stigma associated with mental illness.

B. Workforce Development Specialist (Interim, Inc.)

Objectives:
1. Provide up to ten (10) trainings per fiscal year on skill development areas such as social rehabilitation, Medi-Cal billing, work expectations (i.e. how to receive feedback on work performance) and peer counseling. Topics will be developed by utilizing input from consumers and supervisors.
2. Provide two (2) support groups per month for vocational support of consumers and family members who are employed in the public mental health system.
3. Provide individual job support to thirty (30) consumers. Services to be offered include job coaching, benefits counseling referrals, negotiation of reasonable accommodations and individual counseling.

C. Staff Development and Support Training

Objectives:
1. The WE&T subcommittee will work together to identify effective, evidence-based models for each topic area and determine trainers and most cost effective manner to provide these trainings.
2. Provide annual trainings and ongoing consultations to develop staff competencies in effective models for dialectical behavior therapy, trauma assessment and treatment, treatment of patients with co-occurring disorders, as well as recovery and resiliency principles.
3. Incorporate into trainings specific cultural, gender, economic and spiritual issues which need to be addressed to better serve the diverse population of the County.
4. Provide translation and interpretation services for non-English speaking trainees who are direct service providers.
5. Provide seminars regarding holistic health and alternative healing practices.
6. Provide orientation to all new staff, which includes an overview of the public mental health system, customer service, the recovery oriented philosophy and the services needs of a multicultural and diverse community.
7. Coordinate all training efforts with state-sponsored training and with other counties in the region to reduce duplication.

D. Integrating Cultural Competence in the Public Mental Health System and Increasing Linguistic Competency of Staff

Objectives:
1. Collaborate with the Southern Bay Area Workforce Collaborative to plan regional trainings.
2. Utilize the California Brief Multicultural Competency Scale Self-Assessment Tool to determine a baseline for Behavioral Health staff and contractors.
3. Provide training which will enhance supervision and support of culturally specific services.
4. Provide trainings specifically focused on the diverse needs of the Latino community as well as the African American, Asian Pacific Islander and other traditionally underserved cultural groups/communities.
5. Provide training in working with alternative and traditional cultural healing and healing methods; develop skills of consumers and family members as service providers.
6. Provide translation and interpretation services for non-English speaking trainees who are direct service providers.
7. Provide additional trainings specifically focused on the diverse needs of other life styles and cultures.
8. Provide interpreter training.

E. Consumer and Family Member Training

Objectives:
1. Provide training that incorporates the principles of wellness, recovery and resilience.
2. Provide training that motivates and empowers consumers and family members to participate in a consumer and family driven system.
3. Provide translation and interpretation services for non-English speaking consumers and family members to insure training will be available to all community members.

F. Continue to Support the Local Master of Social Work (MSW) Program

Objectives:
1. Work in partnership with CSU Monterey Bay and other community partners to incorporate regional community needs into the MSW program.
2. Participate in community advisory board, field placement subcommittees and resource development subcommittees.
3. Monitor implementation of scholarships for MSW students.
4. Coordinate field placements for current MSW students and bachelor level students seeking to get into program.

G. Stipends and Incentives

Objectives:
1. Partner with Health Professions Education Foundation to increase applicants for the Mental Health Loan Assumption Program and the Licensed Mental Health Service Provider Education Program.
2. Provide stipends for specific outreach activities related to workforce development and for internships.

H. Law Enforcement/First Responder Crisis Intervention Training (CIT)

Objectives:
1. Increase additional law enforcement personnel, fire personnel, dispatchers and other emergency response personnel trained in CIT.
2. Increase awareness of the signs and symptoms of mental illness and behavioral disorders.
3. Decrease stigma associated with mental illness or behavioral disorders.
4. Decrease the use of force and minimize risk of harm in crisis situations.
5. Decrease arrest rates for non-criminal behaviors.
6. Provide an integrated service experience for those served by law enforcement, emergency response and mental health personnel.
PROGRAM DESCRIPTION FOR FY 2014-15

A. Staff Development and Training Support

Objectives:
1. Provide annual trainings and ongoing consultations to develop staff competencies in effective models for dialectical behavior therapy, trauma assessment and treatment, treatment of consumers with co-occurring disorders, use of evidence-based practices, as well as recovery and resiliency principles.
2. Incorporate into trainings specific cultural, gender, economic and spiritual issues which need to be addressed to better serve the diverse population of the County.
3. Provide translation and interpretation services for non-English speaking trainees who are direct service providers.
4. Provide orientation to all new Behavioral Health Bureau staff, including an overview of the public mental health system, customer service, the recovery oriented philosophy and the services needs of a multicultural and diverse community.
5. Coordinate all training efforts with state-sponsored training and with other counties in the region to reduce duplication.
6. Coordinate internships within the public mental health system.
7. Ensure that translation and interpretation services are available whenever necessary.

B. Consumer and Family Member Training

Objectives:
1. Provide training that incorporates the principles of wellness, recovery and resilience.
2. Provide training that motivates and empowers consumers and family members to participate in youth guided, consumer informed and family driven systems.

C. Workforce Development Specialist (Interim, Inc.)

Objectives:
1. Provide two (2) support groups per month for vocational support of consumers and family members who are employed in the public mental health system.
2. Provide individual job support to thirty (30) consumers. Services to be offered include job coaching, benefits counseling, referrals, negotiation of reasonable accommodations and individual counseling.

D. California State University Monterey Bay Master of Social Work (MSW) Program

Objectives:
1. Work in partnership with CSU Monterey Bay and other community partners to incorporate regional community needs into the MSW program.
2. Participate in community advisory board, field placement subcommittees and resource development subcommittees.
3. Coordinate field placements for current MSW students and bachelor level students seeking to get into program.
E. Stipends and Incentives

Objective:
1. Partner with Health Professions Education Foundation to increase local applicants for the Mental Health Loan Assumption Program and the Licensed Mental Health Service Provider Education Program.

F. Law Enforcement/First Responder Crisis Intervention Training (CIT)

Objectives:
1. Increase additional law enforcement personnel, fire personnel, dispatchers and other emergency response personnel trained in CIT.
2. Increase awareness of the signs and symptoms of mental illness and behavioral disorders.
3. Decrease stigma associated with mental illness or behavioral disorders.
4. Decrease the use of force and minimize risk of harm in crisis situations.
5. Decrease arrest rates for non-criminal behaviors.
6. Provide an integrated service experience for those served by law enforcement, emergency response and mental health personnel.

PROGRAM DESCRIPTION FOR FY 2015-16

A. Staff Development and Training Support

Objectives:
1. Provide annual trainings and ongoing consultations to develop staff competencies in effective models for dialectical behavior therapy, trauma assessment and treatment, treatment of consumers with co-occurring disorders, use of evidence based practices, as well as recovery and resiliency principles.
2. Incorporate into trainings specific cultural, gender, economic and spiritual issues which need to be addressed to better serve the diverse population of the County.
3. Provide translation and interpretation services for non-English speaking trainees who are direct service providers.
4. Provide orientation to all new Behavioral Health Bureau staff, including an overview of the public mental health system, customer service, the recovery oriented philosophy and the services needs of a multicultural and diverse community.
5. Coordinate all training efforts with state-sponsored training and with other counties in the region to reduce duplication.
6. Coordinate internships within the public mental health system.
7. Ensure that translation and interpretation services are available whenever necessary.

B. Consumer and Family Member Training

Objectives:
1. Provide training that incorporates the principles of wellness, recovery and resilience.
2. Provide training that motivates and empowers consumers and family members to participate in youth guided, consumer informed and family driven systems.
C. **Workforce Development Specialist (Interim, Inc.)**

Objectives:
1. Provide two (2) support groups per month for vocational support of consumers and family members who are employed in the public mental health system.
2. Provide individual job support to thirty (30) consumers. Services to be offered include job coaching, benefits counseling referrals, negotiation of reasonable accommodations and individual counseling.

D. **California State University Monterey Bay Master of Social Work (MSW) Program**

Objectives:
1. Work in partnership with CSU Monterey Bay and other community partners to incorporate regional community needs into the MSW program.
2. Participate in community advisory board, field placement subcommittees and resource development subcommittees.
3. Coordinate field placements for current MSW students and bachelor level students seeking to get into program.

E. **Stipends and Incentives**

Objective:
1. Partner with Health Professions Education Foundation to increase local applicants for the Mental Health Loan Assumption Program and the Licensed Mental Health Service Provider Education Program.

F. **Law Enforcement/First Responder Crisis Intervention Training (CIT)**

Objectives:
1. Increase additional law enforcement personnel, fire personnel, dispatchers and other emergency response personnel trained in CIT.
2. Increase awareness of the signs and symptoms of mental illness and behavioral disorders.
3. Decrease stigma associated with mental illness or behavioral disorders.
4. Decrease the use of force and minimize risk of harm in crisis situations.
5. Decrease arrest rates for non-criminal behaviors.
6. Provide an integrated service experience for those served by law enforcement, emergency response and mental health personnel.
PROGRAM DESCRIPTION FOR FY 2016-17

A. Staff Development and Training Support

Objectives:
1. Provide annual trainings and ongoing consultations to develop staff competencies in effective models for dialectical behavior therapy, trauma assessment and treatment, treatment of consumers with co-occurring disorders, use of evidence based practices, as well as recovery and resiliency principles.
2. Incorporate into trainings specific cultural, gender, economic and spiritual issues which need to be addressed to better serve the diverse population of the County.
3. Provide translation and interpretation services for non-English speaking trainees who are direct service providers.
4. Provide orientation to all new Behavioral Health Bureau staff, including an overview of the public mental health system, customer service, the recovery oriented philosophy and the services needs of a multicultural and diverse community.
5. Coordinate all training efforts with state-sponsored training and with other counties in the region to reduce duplication.
6. Coordinate internships within the public mental health system.
7. Ensure that translation and interpretation services are available whenever necessary.

B. Consumer and Family Member Training

Objectives:
1. Provide training that incorporates the principles of wellness, recovery and resilience.
2. Provide training that motivates and empowers consumers and family members to participate in youth guided, consumer informed and family driven systems.

C. Workforce Development Specialist (Interim, Inc.)

Objectives:
1. Provide two (2) support groups per month for vocational support of consumers and family members who are employed in the public mental health system.
2. Provide individual job support to thirty (30) consumers. Services to be offered include job coaching, benefits counseling referrals, negotiation of reasonable accommodations and individual counseling.

D. California State University Monterey Bay Master of Social Work (MSW) Program

Objectives:
1. Work in partnership with CSU Monterey Bay and other community partners to incorporate regional community needs into the MSW program.
2. Participate in community advisory board, field placement subcommittees and resource development subcommittees.
3. Coordinate field placements for current MSW students and bachelor level students seeking to get into program.
E. Stipends and Incentives

Objective:
1. Partner with Health Professions Education Foundation to increase local applicants for the Mental Health Loan Assumption Program and the Licensed Mental Health Service Provider Education Program.

F. Law Enforcement/First Responder Crisis Intervention Training (CIT)

Objectives:
1. Increase additional law enforcement personnel, fire personnel, dispatchers and other emergency response personnel trained in CIT.
2. Increase awareness of the signs and symptoms of mental illness and behavioral disorders.
3. Decrease stigma associated with mental illness or behavioral disorders.
4. Decrease the use of force and minimize risk of harm in crisis situations.
5. Decrease arrest rates for non-criminal behaviors.
6. Provide an integrated service experience for those served by law enforcement, emergency response and mental health personnel.
Access to Treatment
1 Number 3 Regional Offices
Answer your Questions & Connect you to Mental Health Services!
1-888-258-6029

What can you expect when you call 1-888-258-6029?
Between the hours 8am to 5pm, Monday through Friday, your call is answered by bi-lingual (English/Spanish) Behavioral Health staff. If you are an existing client, your call will be transferred to your Social Worker.

If you have never received Behavioral Health Services in Monterey County you will be asked a few questions, including if you have Medi-Cal. You will then be transferred to a member of the Behavioral Health team at the regional office that is most convenient for you. Regional offices are located in Salinas, King City and on the Monterey Peninsula.

If you do not have Medi-Cal, you will be connected to a member of the Behavioral Health team who will work with you to identify your needs and to connect you to community resources including the Department of Social and Employment Services for Medi-Cal eligibility assistance.

After hours, on weekends and holidays, calls are answered by a local Answering Service with access to interpretation services. They will connect you to the Crisis Team at Natividad Medical Center or, if you are not in crisis, they will take a message and your call will be returned by Behavioral Health the next business day.

Access to Treatment
1 Number 3 Regional Offices
Answer your Questions & Connect you to Mental Health Services!
1-888-258-6029

What can you expect when you call 1-888-258-6029?
Between the hours 8am to 5pm, Monday through Friday, your call is answered by bi-lingual (English/Spanish) Behavioral Health staff. If you are an existing client, your call will be transferred to your Social Worker.

If you have never received Behavioral Health Services in Monterey County you will be asked a few questions, including if you have Medi-Cal. You will then be transferred to a member of the Behavioral Health team at the regional office that is most convenient for you. Regional offices are located in Salinas, King City and on the Monterey Peninsula.

If you do not have Medi-Cal, you will be connected to a member of the Behavioral Health team who will work with you to identify your needs and to connect you to community resources including the Department of Social and Employment Services for Medi-Cal eligibility assistance.

After hours, on weekends and holidays, calls are answered by a local Answering Service with access to interpretation services. They will connect you to the Crisis Team at Natividad Medical Center or, if you are not in crisis, they will take a message and your call will be returned by Behavioral Health the next business day.
Policy

1. To the extent possible, services will be made available to all eligible consumers in a culture language that is preferred by the consumer.
2. To the extent possible, and clinically appropriate, consumers whose preference is a language other than English can request staff assigned to him or her be of similar ethnic background. Monterey County.
3. Behavioral Health will assign staff who speak the language, if available, preferred by the consumer and are of similar ethnic background or who can best understand the consumer’s culture. Similar efforts will be offered in regard to offering contractual providers. Written material will be provided to the consumer in font size 14 (or larger upon request). If needed, an audio tape of the material will be provided. Staff may also be available to read material to the consumer.
4. BHB staff is prohibited from expecting family members and friends to provide translation. Only in unplanned situations will clinical staff utilize clerical staff for interpretation and translation services unless the consumer prefers a family member or friend to do the translation.
5. Interpretation facilitates clear understandable communication between the staff and consumer including subtle meanings, idiomatic expressions, saying, implied meanings, affect tone of voice, facial expressions and other non-verbal cues. Interpreters are the link between persons of different cultures. Interpretation may include assessment of whether words, attitudes and behaviors are considered normal and acceptable in the consumer’s culture.
6. Translation facilitates communication of basic information such as appointment schedules, medication information, information requests, rights and responsibilities, resource availability.
7. Translation does not include clinical interpretation of the clinical interpretation of the consumer’s response.

Procedure
1. Consumers will be asked for language preference for services and their response will be documented on the assessment form that will be kept in their chart record.
2. Consumers requesting services in a language other than English will be assigned, to the extent possible, to bilingual staff.
3. Consumers, who cannot be assigned to bilingual staff, will be provided services through use of an interpreter. Program staff will make arrangements for availability of interpretation services.
4. Only staff authorized by the Department shall be used as interpreters and, to the extent possible, the same interpreter will be scheduled for ongoing sessions.
5. The role of the interpreter is to provide the link between the staff and the consumer. The interpreter will be as unobtrusive as possible, facilitating clear and understandable communication.
6. Beneficiaries who have limited English proficiency are informed of their right to have free language assistance. BHD staff will document that advice.
7. Access (crisis services/inpatient psychiatric) to a 24-hour toll free line (800) 258-6029 to assist staff and consumers for translation services. Access to County or other local agencies (e.g. Defense Language Institute and translation services for deaf and blind) to assist the translation.
8. Chart documentation will clearly indicate use of an interpreter and the consumer’s agreement to use of an interpreter.
9. Translation services will be utilized to gather or provide basic information regarding a consumer’s situation or request.
10. Staff will be encouraged to develop bilingual skills and understanding of cultural issues of the consumer population through staff training and professional-development efforts.
11. BHB staff and contracted providers will be provided with regular mandated cultural competency training
Monterey County Behavioral
Health Policy and Procedure

Policy

1. Materials providing information for consumers will be available in a language understandable to the language-threshold population.
2. Materials that require translation will be reviewed by several people, including the program supervisory and management staff, prior to distribution.
3. All materials will be available at service locations, and program management staff will be responsible to ensure a sufficient quantity is at each location. General information regarding health and mental health will be available in the waiting areas of service programs.

Procedure

1. Materials will be available to the public in English and Spanish. Staff proficient in Spanish will develop all materials requiring translation.
2. All materials will be reviewed at least annually to ensure accuracy and comprehensive.
3. All translated materials will be reviewed by the Cultural Competence Committee to ensure that materials are appropriate and relevant.
4. Translated material will be reviewed by designated staff to ensure it is understandable to the general public.
5. Copies of materials will be available at each service location. The program manager will be responsible to ensure that sufficient quantities of materials are available, and will order reprints as necessary.
6. Staff will be informed of the availability of translated materials and the process for requesting copies for consumers.
7. In the event material is not available in the language of the consumer, reasonable efforts will be made to provide information to the consumer by staff proficient in the consumer’s preferred language. Information in larger print also can be made available upon request, as can audio tapes in the preferred language. Staff also can be available to read the material to the consumer, if necessary.
To ensure information is available and useful to consumers, satisfaction surveys will request consumer feedback.
MONTEREY COUNTY
BEHAVIORAL HEALTH
MENTAL HEALTH
SERVICES ACT

FY18-20
Children’s System of Care – General System Development ............................................................. 215
Adult System of Care - Full Service Partnerships ............................................................................. 227
Adult System of Care – General System Development ................................................................. 239
Access – General System Development ......................................................................................... 243
Innovation............................................................................................................................................ 248
Moving Forward: FY18-20 MHSA Program Plan .............................................................................. 252
Prevention ........................................................................................................................................... 253
PEI-01: Open Access Wellness Centers ............................................................................................ 253
PEI-02: Family Support and Education ............................................................................................. 254
PEI-03: Outreach for Increased Awareness of Early Signs of Mental Illness..................................... 255
PEI-04: Stigma and Discrimination Reduction ................................................................................... 257
PEI-05: Prevention/Peer Services to Older Adults ........................................................................... 258
PEI-06: Suicide Prevention .................................................................................................................. 259
Early Intervention............................................................................................................................... 260
PEI-07: Access Regional Services ....................................................................................................... 260
PEI-08: Student Mental Health ............................................................................................................ 261
PEI-09: Juvenile Justice Diversion ....................................................................................................... 262
PEI-10: Prevention and Recovery for Psychosis Disorders ............................................................... 263
PEI-11: Responsive Crisis Interventions ............................................................................................ 264
Community Services and Supports - Full Service Partnerships (FSP) ..................................................... 265
CSS-01: Family Stability FSP ............................................................................................................... 265
CSS-02: Dual Diagnosis FSP .............................................................................................................. 266
CSS-03: Juvenile Justice FSP .............................................................................................................. 267
CSS-04: Transition Age Youth FSP ...................................................................................................... 269
CSS-05: Adults with Serious Mental Illness FSP ................................................................................. 270
CSS-06: Older Adults FSP ................................................................................................................... 272
Community Services and Supports – General System Development (Non-FSP) Programs ........... 273
CSS-07: Access Regional Services ..................................................................................................... 273
CSS-08: Early Childhood Mental Health ............................................................................................ 275
CSS-09: Transition Age Youth and Young Adult Mental Health ....................................................... 276
CSS-10: Supported Services to Adults with Serious Mental Illness .................................................. 277
CSS-11: Dual Diagnosis ..................................................................................................................... 278
CSS-12: Family Stability..................................................................................................................... 279
DIRECTOR’S LETTER

AUGUST 2017

Welcome to Monterey County’s “FY 18-20 Mental Health Services Act (MHSA) 3-Year Program Plan and Budget.”

This MHSA Plan was built using an extensive community feedback process to engage with underserved communities in new ways. As you will see in the following pages, we used data to identify the underserved zip codes in Monterey County. With the assistance of our partners, we surveyed residents of those communities to learn about their service needs and preferences. We also conducted fourteen focus groups involving youth, parents, seniors, clients, peer advocates, those experiencing homelessness and others, often in collaboration with our providers and other partners. Throughout our planning process, we attempted to engage with the community in more meaningful ways, because if we continue with “business as usual”, the inequities in our system will persist. This MHSA Plan also builds upon the “Governing for Racial Equities” initiative, which has been prioritized by the Health Department and endorsed by the Monterey County Board of Supervisors.

In Monterey County, we have a large safety net population, with 168,000 currently enrolled in Medi-Cal, and an estimated 40,000 to 70,000 undocumented residents. The Behavioral Health Bureau’s mandate is to serve this safety net population. 75% of the safety net population is Latino, yet only 54% of individuals receiving services from Monterey County Behavioral Health and our extensive network of contract providers, identify as Latino. Simply stated, we are currently underserving the Latino population by 21%. These may just seem like numbers, yet what happens to our most vulnerable residents when the safety net provider is not equitably distributing the services? By definition, if the safety net fails to meet the needs of the Latinos in Monterey County, there aren’t any providers below the safety net to meet the needs of these residents. And when the safety net fails, there can be significant impacts on individuals, families, and the communities in which they live.

Monterey County Behavioral Health’s goal is to increase services to the Latino population by five percent (5%) in five (5) years. To reach this goal, we have prioritized new MHSA Innovation projects to help us identify and implement innovative strategies to more effectively engage the Latino communities in Monterey County. We have also worked closely with the Mental Health Commission to review how each MHSA-funded program is addressing health equity, and to make recommendations to help us reach our equity goals. We will continue prioritizing services to the South County region as well as in Salinas, where the highest concentration of Latinos resides.

The Country’s economic forecast, especially in terms of federal health care reform and the potential impacts on local healthcare funding, remain uncertain as we present this draft MHSA Plan for your review and comment. However, whatever changes are made in Washington, D.C. to the Affordable Care Act, our mandate to serve the safety net population will remain.

Please join me in our efforts to build an equitable system of care for Monterey County.

AMIE MILLER, MFT, PSY. D.
BEHAVIORAL HEALTH DIRECTOR
INTRODUCTION

PURPOSE OF THE 3-YEAR PLAN

This FY18-20 MHSA 3-Year Program and Expenditure Plan for Monterey County has been created to satisfy funding requirements set forth by Welfare and Institution Code (WIC) 5847 and authorized by the California Mental Health Service Oversight and Accountability Commission. The intended purpose of this document is to provide residents, stakeholders and service providers with an overview of planned MHSA funded activities in Monterey County over FY18-20. Additionally, this 3-year planning effort offers Monterey County Behavioral Health (MCBH) and its community the opportunity to reassess our accomplishments, failures, community needs and goals in the context of the current social, economic and political landscape.

This Plan introduces a new direction for MHSA funded activities in Monterey County, and is dedicated to making our local mental health system more responsive, impactful, efficient and resilient. The number of programs supported by MHSA funds has grown dramatically since its inception in 2005. As this growth has been beneficial for developing broader infrastructure for mental health services in Monterey County, this FY18-20 planning period now presents an opportunity to redirect and focus MHSA investments to better conform to the needs of our communities. The plan put forward in this document is to consolidate MHSA programming efforts in Monterey County, to enhance those services proven to be successful and adopt new programs for resolving current challenges.
MENTAL HEALTH SERVICES ACT

BACKGROUND

In 2004, California voters approved Proposition 63 to enact the Mental Health Services Act (MHSA) with the intention of expanding and transforming public mental health systems across the state. More than two million children, adults and seniors in California are affected by a potentially disabling mental illness each year. The MHSA was created, and approved by Californians, to create a mental health system that can guarantee the same level of care already extended to those who face other kinds of disabilities. Failure to address and treat mental illness as a public health issue not only creates grief and emotional pain, but it undoubtedly imposes significant public costs from increased levels of hospitalizations, unemployment, homelessness, academic failure and incarcerations. The MHSA was approved to enable local jurisdictions to build capacity to implement robust systems of care for greater accessibility and effectiveness of treatment services across the continuum of prevention to recovery. The MHSA was also approved to develop a skilled workforce and build cultures of acceptance and awareness of mental health issues and resources throughout their communities.

The MHSA generates dedicated funding by an additional 1% tax imposed on California residents with personal incomes greater than one million dollars. MHSA funds accumulated by the State are then redistributed to each mental health jurisdiction (all 58 counties, and 2 cities) according to their population size. To receive MHSA funds, jurisdictions must produce and locally approve a stakeholder informed plan to describe how funds will be utilized. Local MHSA plans must include services for all ages, and may also fund programs specific the age groups of children (0-16 years), transition age youth or TAY (16-25 years), adults (26-59 years) and older adults (60 years and older). MHSA programs must also comply with the MHSA funding component service descriptions and reporting requirements as set forth in the regulations.

All programs funded by the MHSA must be guided by the following MHSA Guiding Principles:
**MHSA Funding Components**

**Community Services & Supports (CSS)** –
Eighty-percent (80%) of MHSA funds received by counties must be allocated for the CSS component. MHSA funds may only be used to pay for those portions of the mental health programs/services for which there is no other source of funding available. CSS programs serve individuals affected by moderate to severe mental illness and their families. These services are community based, recovery-oriented and culturally competent. Funding can only be used for voluntary services and no less than fifty-percent (50%) must be allocated to “full service partnerships” (FSP). FSP services provide a “whatever it takes” level of services, also referred to as “wraparound” services, to support the most severely mentally ill clients and their families, twenty-four hours a day, seven days a week. These wraparound services include treatment, case management, peer support, transportation, housing, crisis intervention, family education, vocational training and employment services, as well as socialization and recreational activities, based upon the individual’s needs to obtain successful treatment outcomes.

**Prevention & Early Intervention (PEI)** – Twenty-percent (20%) of MHSA funds received by counties must be allocated for PEI services, designed to prevent mental illnesses from becoming severe and disabling. PEI services focus on preventing the onset of mental health issues and/or providing early intervention treatment and referral services. MHSA regulations require PEI plans to include at least one program focused on delivering services for each of the following service categories: 1) Prevention, 2) Early intervention, 3) Stigma and discrimination reduction, 4) Recognizing early signs of mental illness, and 5) Promoting greater access and linkage to treatment. Suicide prevention programs also fit within the PEI component. All programs must employ strategies for promoting access and linkage to treatment, improving timely access to services for underserved populations, and utilizing non-stigmatizing and non-discriminatory practices. Counties must serve all ages in one or more programs funded by the PEI component. At least fifty-one percent (51%) of PEI funds must be allocated for serving individuals who are 25 years old or younger. Programs that serve parents, caregivers or family members with the goal of addressing children and youth at risk of or with early onset of a mental illness can be counted as serving children and youth.

**Innovation (INN)** – Funds for the INN component consists of five percent (5%) of CSS funds and five percent (5%) of PEI funds received by the County. Innovation Programs are defined as novel, creative, and/or ingenious mental health practices or approaches that are expected to contribute to learning, which are developed within communities through a process that is inclusive and representative of unserved and underserved individuals. The Innovation Component allows counties the opportunity to “try out” new approaches that can inform current and future mental health practices/approaches and contributes to learning rather than having a primary focus on providing a service. Innovation projects can only be funded one time and are time-limited. Innovation projects must also use quantifiable measurements to evaluate.
their efficacy.
**WET programs** are intended to enhance the recovery-oriented treatment skills of the public mental health service system and to develop recruitment and retention strategies for qualified professionals serving community mental health. Education and training programs are consumer-centered, culturally competent, and driven by the values of wellness, recovery, and resiliency. Funds for WET were provided to counties as a one-time distribution in 2007. In Monterey County, WET funds were invested to conduct a workforce needs assessment, workforce training and education activities, as well as a feasibility study on the development of a local Graduate Program in Social Work (MSW). In collaboration with California State University Monterey Bay, the Master in Social Work Program was created, and in 2010, began accepting students into the program. MCBH is the currently the largest internship site for CSUMB MSW students.

**Capital Facilities funds** allow counties to acquire, develop or renovate buildings to house and support MHSA programs. Technological Needs funds support counties in transforming and modernizing clinical and administrative information systems as well as increasing consumer and family member’s access to health information within a variety of public and private settings. In Monterey County, CFTN funds were used to acquire and renovate the Integrated Health Center in Marina, as well as implement “Avatar”, an electronic medical record system utilized by County Behavioral Health staff and many of our contract providers.

**Recent Changes to the MHSA**

In 2016, the MHSOAC issued regulatory changes regarding the intent and reporting requirements of PEI Programs. Explained in the PEI section above, these new regulations mandate there be at least one PEI program to serve five new service goals, and three new strategies to be employed in all PEI programs. In addition to tracking outcomes on effectiveness of services, there are also new reporting requirements to capture the demographics of persons served, including age, race, ethnicity, primary language, sexual orientation and gender identification, and disability. The regulations also include a specific focus to “prevent mental illness from becoming severe and disabling” for all PEI programs.

Also, in 2016, the State of California approved the “No Place Like Home” (NPLH) legislative initiative to develop permanent supportive housing for chronically homeless individuals who need mental health and/or co-occurring substance abuse services. NPLH is funded by a diversion of $2 billion of MHSA funds from the annual amount accumulated by the State. These diverted funds are to be re-allocated based on county population beginning in FY 19. Monterey County is estimated to receive $3.3 million to create permanent housing for chronically homeless persons with mental illness. Additional funding for services and supports for those individuals placed in the new permanent housing will need to be identified from other sources than the NPLH initiative.
MONTEREY COUNTY DEMOGRAPHICS

Monterey County is located on the Central Coast of California, 106 miles south of San Francisco and roughly 250 miles north of Los Angeles. The region is well known for its iconic coastlines along Monterey Bay and Big Sur, as well as its fertile Salinas Valley that is dubbed the “Salad Bowl of the World.” With a total population of 428,441, and land mass area of 3,281 square miles, much of Monterey County is sparsely populated and rural, with most development being clustered at the northern end of the Salinas Valley and toward Monterey Peninsula at the coast. The City of Salinas is the county seat and its largest city, as well as the hub of the agricultural sector of the economy. Monterey County is the third largest agricultural county in California and the agricultural sector supplies most jobs in the county. Government and Tourism are the second and third largest sectors of the county economy, respectively, with Post-Secondary Education and Specialized Business Services in the technology sector expected to show the highest rates of growth in coming years. Monterey County also carries a military presence, as it is home to three Army bases, a Coast Guard Station, the Defense Language Institute and Naval Postgraduate School.¹

GENDER & AGE

The median age in Monterey County is 33, trending a couple years younger than the state median. Adults ages 25-59 make up 46% of the population, with Older Adults aged 60+ making up another 17%. Children under 5 years old represent 8% of the population, while Youth ages 5-15 and Transitional Age Youth (TAY) ages 16-24 equally represent 15% of the population. Regarding gender, 51% of Monterey County residents are male and 49% are female.

¹Unless otherwise noted, all demographic data is sourced from US Census FactFinder: https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml
ETHNICITY, RACE & LANGUAGE

Hispanic/Latino individuals represent the majority of Monterey County residents, at 57% of the population. The remainder of the population is comprised of individuals identified as White (32%), Asian (6%), African American (3%), Native Hawaiian and Other Pacific Islander (1%) and Native American and Other representing 2% of the population. As may be expected, with the majority population being Hispanic/Latino, Spanish is the most common language spoken at home (47% of the households in Monterey County). English is the preferred language in 46% of households, while 4% prefer Asian or other Pacific Islander languages, 2% prefer an Indo-European language, and 1% speak a Other Language. Similarly, Hispanic/Latino individuals and a preference for Spanish language services are the majority groups in the Medi-Cal beneficiary population as well.
Monterey County has four geographic regions: The Salinas Valley, the Coastal Region, North County and South County. The Salinas Valley region is comprised of the City of Salinas and immediately adjacent towns. The Coastal Region encompasses all cities on the coast from Marina to Big Sur, and includes Carmel Valley. North County is made up of the small, rural and/or agricultural towns and districts north of Salinas. South County is the expansive area of Monterey County south of Salinas. The South County region consists of several larger cities with populations above 15 and 30 thousand people, as well as several remote, sparsely populated rural districts. Figure 4 illustrates the distribution of Medi-Cal beneficiaries across these geographic regions. As the City of Salinas is by far the most populous area of the county, its region has a corresponding majority of beneficiaries. Alternatively, the combined cities of the Coastal Region that total a population size close to that of Salinas has a proportionally low number of Medi-Cal beneficiaries. The relatively small North County region has an equal proportion of beneficiaries, while about 1 in 5 Medi-Cal beneficiaries in Monterey County are found in the expansive South County region. As the “safety net” mental health care provider, being aware of the geographic distribution of Monterey County’s highest-needs populations is critical for effective planning and service delivery.

**INCOME, HOUSING & POVERTY**

The total number of housing units in Monterey County is 139,794, with 49% being owner-occupied. As with much of coastal California regions, Monterey County has a high cost of living relative to income levels. The average home value in Monterey County is $506,300 and the average household income is $58,783. For the 51% of residents that are renters, nearly 47% incur rental costs that are greater than 35% of their household income. The total poverty rate in Monterey County is 17%, with 25% of all children in Monterey County living below the poverty level. The latest Monterey County Homeless Census conducted by Applied Survey Research found there are approximately **2,308 INDIVIDUALS WHO ARE HOMELESS IN THE COUNTY**.  

---

2 Applied Survey Research. 2015 Monterey County Point-In-Time Homeless Census & Survey, Watsonville CA
The Monterey County Behavioral Health Bureau (MCBH) is a division within the Monterey County Health Department (MCHD). As such, MCBH works in congruence with the strategic goals and operations of MCHD, at the direction of the Monterey County Board of Supervisors. The MHSA funds a significant portion of the programs and administrative activities implemented by MCBH, specifically those operating in alignment with MHSA funding component guidelines. MHSA funds constitute 17% of MCBH annual revenues and MHSA funds support, at least partially, 71% of the programs currently implemented by MCBH. MCBH programs operating outside the scope and purview of the MHSA include the provision of additional mental health treatment services, inpatient hospital services, support for Institutions for Mental Disease (IMD) and Skilled Nursing Facilities (SNF), out-of-home placements, administration of integrated care and crisis response programs, Critical Incident Stress Management partnerships with law enforcement, and provision of substance use prevention and substance use disorder (SUD) treatment programs. Non-MHSA funding for MCBH administration and other services is received from the Monterey County General Fund which fulfills the State’s Maintenance of Effort requirement for the distribution of Realignment funds and other categorical revenue sources specific to mental health and SUD services. MCBH also receives federal Community Mental Health Block Grant and Projects for Assistance in Transition from Homelessness funds and recently was awarded a state Proposition 47 grant for the “No Zip Code Left Behind” initiative. This $6 million grant will fund new SUD treatment services in King City as well as a centrally located sobering center, job training, case management and other services.

**MCBH SYSTEMS OF CARE**

The MCBH organization consists of three distinct systems of care. These are the Adult System of Care (ASOC), the Children’s System of Care (CSOC), and Access to Services (ACCESS), which is open and available to all age groups. MCBH also contracts with community service providers to administer programs in each of the systems of care.

As the label implies, ACCESS services function as entry points into the behavioral health system. ACCESS programs serve both children and adults, and feature walk-in clinics in three regions of the county to provide assessment, early intervention and referral services. ACCESS clinics are in Marina, Salinas, Soledad and King City, with staff also providing services on a limited basis in Castroville. ACCESS also has a toll-free line available for speaking with a Social Worker during business hours. After-hours calls are answered by Crisis Intervention Specialists. Welcome and Orientation groups are held at each Regional site several times a week. The groups offer education about services, and brief assessments to refer individuals and families to the appropriate services. Services provided in ACCESS after an assessment may include up to 6 months of brief therapy, medication support, and case management. ACCESS serves primarily Medi-Cal beneficiaries; if a County resident is not currently a Medi-Cal beneficiary and is seeking services, they are referred to a member of the ACCESS team who will help identify their needs and connect them to benefits.
or other community resources.

In August 2008, Behavioral Health created a crisis support team within ACCESS. The team consists of specially trained Behavioral Health staff who are available to individuals, first responders, organizations and employers in the community to facilitate debriefings following a critical or traumatic incident such as learning about the sudden death of a co-worker, or witnessing a tragic event. Behavioral Health staff assist people to work through the initial stages of grief and provide self-care tips and resources. As expressed by a member of the Behavioral Health Crisis Team: “WE HELP INDIVIDUALS WORK THROUGH ALL THE EMOTIONS THEY ARE FEELING: ANGER, SADNESS AND FEAR, AND WE HELP THEM RESTORE A SENSE OF CONTROL. AS NECESSARY, WE CONNECT INDIVIDUALS WITH RESOURCES FOR CONTINUED CARE AND SERVICES.”

CSOC and ASOC services support prevention and early intervention efforts, however, most the services are focused on providing more intensive intervention and treatment. CSOC serves both Children and TAY. ASOC primarily serves adults and older adults, although TAY may also qualify for ASOC services. The intensive services provided in these systems of care include individual, family and group therapy, medication support and case management. Services are provided to children and youth with severe emotional disturbances and to adults and older adults who have a chronic and persistent mental illness. This includes individuals diagnosed with schizophrenia, bipolar disorder, and atypical psychosis. A 24-hour crisis team is located at Natividad Medical Center’s Emergency Department. Assessment for acute care, including inpatient psychiatric services when indicated, is available. Services at all sites are delivered by staff who are licensed behavioral health professionals. Staff are both multi-lingual and multi-cultural. Languages served include Spanish, Polish, American Sign, Tagalog, and Portuguese. MCBH also contracts with service providers that complement CSOC and ASOC services in providing crisis residential services, supported housing, employment, education, and dual diagnosis treatment.

**MCBH STRATEGIC PLAN**

Over the course of FY13-14, MCBH conducted a thorough community planning process to develop the Monterey County Behavioral Health Strategic Plan. This community planning process engaged numerous community members and service providers. All systems of service delivery, ranging from prevention and early intervention, to treatment and aftercare, were examined. Facilitators worked with participants to identify and prioritize key areas of improvement and continued support. In total, 2,667 IDEAS and recommendations were collected from participants and used to formulate recommendations for system and program improvement detailed in the Strategic Plan document. ([http://www.co.monterey.ca.us/government/departments-a-h/health/behavioral-health/behavioral-health-strategic-plan](http://www.co.monterey.ca.us/government/departments-a-h/health/behavioral-health/behavioral-health-strategic-plan)). The Strategic Plan, which was reviewed and approved by stakeholders and the Mental Health Commission, continues to offer meaningful guidance. To make best use of this document and the community planning efforts that went into its development, MCBH is continually seizing opportunities to deliver on its strategic, community-informed goals. MCBH recognizes this FY18-20 MHSA 3-Year Program and Expenditure Plan as a significant opportunity to reframe the structure of MHSA programs and funding allocations to further advance the
strategic goals for the delivery of mental health services for Monterey County residents. Specifically, beginning with this FY18-20 Plan, MHSA PEI and CSS programs are categorized according to the community-identified strategic plan service populations, within their respective MCBH System of Care. This program framework will enable more focused delivery and accountability of services to the appropriate populations. These populations include:

<table>
<thead>
<tr>
<th>STRATEGIC SERVICE POPULATION</th>
<th>SYSTEM OF CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 EARLY CHILDHOOD INTERVENTION</td>
<td>CSOC</td>
</tr>
<tr>
<td>ADOPTION PRESERVATION</td>
<td>CSOC</td>
</tr>
<tr>
<td>STUDENT MENTAL HEALTH</td>
<td>CSOC</td>
</tr>
<tr>
<td>CHILDREN INVOLVED IN SOCIAL SERVICES</td>
<td>CSOC</td>
</tr>
<tr>
<td>CHILDREN AT RISK OF PLACEMENT</td>
<td>CSOC</td>
</tr>
<tr>
<td>TRANSITION AGE YOUTH</td>
<td>CSOC</td>
</tr>
<tr>
<td>JUVENILE JUSTICE</td>
<td>CSOC</td>
</tr>
<tr>
<td>ADULT SERVICES</td>
<td>ASOC</td>
</tr>
<tr>
<td>HOMELESS</td>
<td>ASOC</td>
</tr>
<tr>
<td>ADULTS INVOLVED IN THE CRIMINAL JUSTICE SYSTEM</td>
<td>ASOC</td>
</tr>
<tr>
<td>RESIDENTIAL PLACEMENT / SUPPORTED HOUSING</td>
<td>ASOC</td>
</tr>
<tr>
<td>DUAL DIAGNOSIS</td>
<td>ASOC</td>
</tr>
<tr>
<td>ACCESS SERVICES</td>
<td>ACCESS</td>
</tr>
<tr>
<td>CRISIS &amp; HOSPITALIZATION*</td>
<td>ACCESS</td>
</tr>
<tr>
<td>SUBSTANCE USE DISORDER PREVENTION AND TREATMENT*</td>
<td>ACCESS</td>
</tr>
</tbody>
</table>

*Note: Crisis & Hospitalization and Substance Use Disorder Prevention and Treatment are not funded by the MHSA.

Figure 7: Strategic Populations and System of Care

In addition to aligning the MHSA program planning efforts with MCBH strategic service populations, our FY18-20 MHSA 3-Year Program and Expenditure Plan also takes into consideration the following key themes of interest among Monterey County stakeholders:

- **OUTREACH EDUCATION AND PROMOTION OF SERVICES**, specifically about the availability of services and to address stigma.
- **SERVICE IMPROVEMENT AND EXPANSION** for prevention and recovery services, family supports, supported housing, and alcohol and other drug treatment services.
- **ACCESS AND SYSTEM NAVIGATION**, particularly related to timeliness of services, transportation, regional health equity, and engagement with high needs populations.
**Striving for Health Equity**

The Monterey County Health Department (MCHD) is the 2017 recipient of the California Endowment’s 2017 Arnold X. Perkins Award for Outstanding Health Equity Practice. This prestigious honor was awarded in recognition of the County’s effort to ensure that all citizens, regardless of their health status, ability, race, gender, sexual orientation, socio economic status and geographical location, have the capacity to obtain the same positive health outcomes. Monterey County strives to provide *equitable - not equal - access*. Equal access emphasizes process and involves providing the same opportunities and mechanism for all citizens to receive health care, independent of need; equitable access involves outcomes and involves making sure that all citizens have the same ability to achieve wellbeing and healthful outcomes, even if this means providing different levels of opportunity or different mechanisms of promoting health. (Please see the figure below for a graphical representation of this concept.)

Two notable components of MCHD’s health equity effort are the Health Equities Scholarship Academy (the Academy), developed in 2014, and the County’s participation in the Government Alliance on Race and Equity (GARE), which started in 2016. The Academy helps participants learn to work within the governmental process to address health inequalities and injustices in our local communities. The Academy is based on the principle that differences in status generate differences in health outcomes, unlike the conventional view of health disparities that attributes health disparities to access and personal behavior. Training is interactive and attempts to bring forth the life experiences of participants for a more enriching learning experience. Since inception, 82 individuals, from all seven bureaus of the Health Department, have participated in the Academy. Of those participants, 21% were from the Behavioral Health Bureau.

GARE is a national network of government employees working to achieve racial equity and advance opportunities for all. GARE participants engage in a 12-month training process where they learn strategies and tools to help identify and remediate racial inequities that impact the citizens of their jurisdictions. Two of the 7-member Monterey County GARE Committee are Health Department employees; one of these employees is the MCBH Training Manager.

MCBH is focused on improving racial and regional health equity for Monterey County citizens. To ensure the appropriate service levels are available and provided, MCBH looks to our local Medi-Cal beneficiary demographics (also referred to as the safety net population) as the benchmark for how services are designed, marketed and provided. Using this gauge, the parity point to achieve health equity occurs when the demographics of clients served by MCBH, along with the value of services provided, match the demographics of the Medi-Cal beneficiary population.
When viewing the ethnic breakdown of Medi-Cal beneficiaries in Monterey County next to the data on clients served by MCBH and local service providers, it is apparent the Hispanic/Latino citizens are significantly underserved. Also, they are receiving a disproportionality low value of services per clients than other ethnicities. This disparity is also reflected in the languages in which services are provided. The data characterizes a disproportionate amount of services not reaching the Spanish speaking, Hispanic/Latino communities most in need.

MCBH has taken many steps to remedy inequity, including developing two new outpatient clinics in South County and directing new funding opportunities for use in South County, for example the Proposition 47 funded initiative “No Zip Code Left Behind”, which will expand substance use disorder treatment services in South County.

The data also illustrates the mismatch in service value delivered across the 4 regions of Monterey County. The value of services delivered per client in the Coastal Region is significantly higher than the cost of services per client in Salinas Valley, North County and South County Regions. Historically, South County has been chronically underserved with a lack of available resources. To achieve health equity in Monterey County, more resources need to be dedicated to serving the South County Region.
COMMUNITY PROGRAM PLANNING (CPP) PROCESS

Monterey County Behavioral Health engaged the public, our stakeholders, staff and community service providers in the MHSA Community Program Planning (CPP) Process starting in June 2016. From the outset, the planning process was designed to hear from residents across the cultural, ethnic and geographic landscape of the county to inform the Monterey County FY18-20 MHSA 3-Year Program & Expenditure Plan. The CPP process was implemented with the following three (3) goals in mind:

1. **Identify Those Individuals with Persistent Mental Health Issues in Monterey County that Have Not Been Served, or Have Been Inadequately Served, by Previous MHSA Funded Activities.**

2. **Analyze the Issues ExpRESSED During the CPP Process in the Context of MHSA Funding Component Guidelines and the MCBH Strategic Framework.**

3. **Assess Opportunities to Alter, Expand or Create MHSA Funded Programs to Address the Issues That Emerged from the CPP Process.**

The MHSA CPP process was then carried out in three (3) phases. In the first phase, focus groups were conducted across the County. In the second phase, one-on-one surveys were administered in strategically significant zip code areas. The third phase is to receive public comment on this FY18-20 MHSA 3-Year Program and Expenditure Plan over the required 30-day public review and comment period. Additionally, it is very important to highlight the work and dedication of the Monterey County Mental Health Commission and the Monterey County MHSA Evaluation Ad Hoc Committee. The Commissioners and Committee members have supported and guided the MCBH throughout this process – from start to finish - to evaluate and enhance our local MHSA program planning with a community-driven perspective.
MONTEREY COUNTY MENTAL HEALTH COMMISSION’S MHSA EVALUATION AD HOC COMMITTEE

At the request of the Mental Health Commission Chair at the June 30, 2016 meeting, Commission members volunteered to be appointed to the MHSA Evaluation Ad Hoc Subcommittee to work with MCBH staff and give the Commission’s input for the 2017 MHSA Plan Annual Update. This input also forms the foundation for this MHSA 3-Year Program and Expenditure Plan covering FY 17-18 through FY 19-20. Between September 2016 and June 2017, ten (10) meetings were convened, typically immediately preceding the regular Mental Health Commission meeting. Over the course of the ten months, Behavioral Health Director Amie Miller and staff presented the following for the Commission members consideration:

1. A “Proposal: How We Will Describe Programs for the Upcoming FY18-20 MHSA 3-Year Program & Expenditure Plan.” The Commission members shared their suggestions for what kinds of information and what formats would be useful in the upcoming MHSA Plan document;
2. A proposed structure that could be used to rank programs according to criteria such as addressing disparities, reaching the underserved and providing equitable services. The Commission members also discussed ways to go out into the community and engage in a dialogue about unmet needs;
3. A document showing the “continuum” of MHSA funded services;
4. A revised draft of the proposed MHSA Program Review/Evaluation structure (See Appendix I for “MHSA Program Review to Support the 3-Year Plan Development” and corresponding “MHSA Program Evaluation Structure”). The Commission provided feedback on the proposed structure and how it could be presented to the general public;
5. Preliminary data from the Underserved Communities (by Zip Code) Survey, conducted by the Center for Community Advocacy, the Health Department’s enLACE program staff, and the PEI Coordinator, in the zip code areas where there are high concentrations of Latino residents who are not yet engaged in the community mental health system.

CPP PROCESS PHASE 1: FOCUS GROUPS

Between February and June 2017, staff conducted a total of 13 one-hour planning sessions using the MHSA focus group guide (See Appendix II). Seven groups were conducted in English and six were conducted in Spanish. These feedback sessions were advertised and conducted with the support of several local stakeholder groups and community partners, to whom MCBH expresses its gratitude and appreciation. These local organizations included The EpiCenter, enLACE, Skittles Group at Main St. Middle School, Promotores and Youth For Change with the Center for Community Advocacy, The Alliance on Aging, the Secure Families Group, the Recovery Task Force, Partners for Peace Youth Group, Voice of the Voiceless, and the Chinatown Learning Center Collaborative, administered by Interim, Inc. with California State University Monterey Bay. Planning sessions were open to all community members interested in...
participating, and were held in King City, Soledad, Salinas, Castroville and the Peninsula, to provide access to residents in each of the 4 regions of Monterey County. Demographics represented in these meetings included MCBH consumers and their families, Latino youth, women and families, LGBTQ teens and adults, older adults, homeless and System Impacted Adults. In total, 232 individuals participated in this phase of the CPP process.

<table>
<thead>
<tr>
<th>FOCUS GROUP</th>
<th>DATE</th>
<th>CITY &amp; REGION</th>
<th>POPULATION</th>
<th>NUMBER OF PARTICIPANTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Epicenter</td>
<td>2/12/2017</td>
<td>Salinas</td>
<td>LGBTQ teens and adults</td>
<td>25</td>
</tr>
<tr>
<td>enLACE</td>
<td>2/14/2017</td>
<td>King City, South County</td>
<td>Latino women</td>
<td>50</td>
</tr>
<tr>
<td>Skittles Support Group at Main St. Middle School</td>
<td>2/15/2017</td>
<td>Soledad, South County</td>
<td>LGBTQ teens</td>
<td>40</td>
</tr>
<tr>
<td>enLACE</td>
<td>2/23/2017</td>
<td>Castroville, North County</td>
<td>Latino families</td>
<td>15</td>
</tr>
<tr>
<td>Promotores, CCA</td>
<td>3/7/2017</td>
<td>Salinas</td>
<td>Latino Health Promoters</td>
<td>11</td>
</tr>
<tr>
<td>Secure Families Group</td>
<td>3/7/2017</td>
<td>Salinas</td>
<td>MCBH consumers</td>
<td>5</td>
</tr>
<tr>
<td>Recovery Task Force</td>
<td>3/16/2017</td>
<td>Salinas</td>
<td>Consumers</td>
<td>15</td>
</tr>
<tr>
<td>The Alliance on Aging</td>
<td>3/23/2017</td>
<td>Salinas</td>
<td>Older Adults</td>
<td>9</td>
</tr>
<tr>
<td>The Alliance on Aging</td>
<td>4/4/2017</td>
<td>Peninsula</td>
<td>Older Adults</td>
<td>15</td>
</tr>
<tr>
<td>Partners for Peace Youth Group</td>
<td>4/5/2017</td>
<td>Salinas</td>
<td>Latino Youth</td>
<td>20</td>
</tr>
<tr>
<td>Voice of the Voiceless</td>
<td>4/19/2017</td>
<td>Salinas</td>
<td>System Impacted Adults</td>
<td>10</td>
</tr>
<tr>
<td>Youth for Change, CCA</td>
<td>4/19/2017</td>
<td>Salinas</td>
<td>Latino Youth</td>
<td>10</td>
</tr>
<tr>
<td>Chinatown Learning Center, Interim Inc.</td>
<td>6/13/2017</td>
<td>Salinas</td>
<td>Homeless Adults</td>
<td>7</td>
</tr>
</tbody>
</table>

Total 232

FIGURE 11 CPP PROCESS FOCUS GROUPS

COMMUNITY FEEDBACK FROM FOCUS GROUPS

The focus groups were successful in eliciting feedback on barriers and challenges faced by Monterey County residents when attempting to access mental health services. Participants also provided constructive insights to improve access and quality of care. To begin with, various roadblocks were noted by those participants who have tried to navigate the public mental health system. Of those who engaged with the system, some felt that more could be done to make the environment and experience be more welcoming. Focus Group participants offered insight on where and how they might feel more comfortable receiving services, and how they would like to see more investment in community outreach, stigma reduction and prevention.
System navigation can be negatively impacted by inadequate signage and feelings of being overwhelmed. One participant stated,

“NATIVIDAD HOSPITAL IS HARD AND CONFUSING TO NAVIGATE. IT DOES NOT HAVE SIGNAGE INDICATING WHERE YOU CAN ACCESS MENTAL HEALTH SERVICES THERE. I GOT LOST THE FIRST TIME I WAS THERE. IT WOULD BE BENEFICIAL TO HAVE SIGNAGE AND A GUIDE OR SOMEONE WELCOMING YOU AND ORIENTING YOU TO MENTAL HEALTH SERVICES.”

A few other participants saw value in investing in navigators, saying “we need to invest in peer navigation programs. It would be great to have someone welcome, orient, and give information on resources to new patients.” Consumers of mental health services also cited the need for their social workers, psychologists, and other mental health service providers to be aware of community mental health services and supports and other non-mental health resources, in order to support their ability to acquire referrals and find their way to appropriate services. Clients would like to be connected to community resources that they might need in addition to therapy and medication. One client stated, “I was connected to a social worker when I was homeless. I needed housing and she wanted to give me therapy. I really had to push her to get what I really needed. They [social workers] need to be better at connecting clients to resources and knowing what the resources are.” Other participants felt that “patients have no sense of direction and don’t know what to do” and “it is important to have social workers understand what is going on in our county: for example, resources and how to access them.”
CREATE MORE WELCOMING ENVIRONMENTS & IMPROVE CUSTOMER SERVICE

Some participants who have utilized services felt there was room for improvement in making services and clinics feel more welcoming and inclusive. Participants shared that the way they are treated and the physical environment matter when they access mental health services. Participants mentioned that when they are not treated with respect and concern, they are unlikely to come back for services and will likely influence and discourage other people from using services. One person remarked, “How does the crisis team work? I tried to connect a community member to them and called them first to ask how it works. They explained how it works to me and I told them that I was going to refer someone to them. When my referral called, they were so rude to them and told them, ‘I already explained to the other person who called how it works. Didn’t they explain to you? You should call the police.”

Groups put forward solutions for improving levels of customer service. Recommendations included trainings on customer service for staff answering phones. Other creative solutions were to give mental health clinics “art, soothing music, plants, signage, something that makes you feel comfortable and welcomed” and “create new ways to communicate and reach out to peers and increase peer participation in the waiting rooms.” LGBTQ participants shared that having a poster/sign that lets the LGBTQ community know they are welcomed can send the message that the office is a safe space. However, they added that having a sign is not enough and that trainings for the staff to understand the LGBTQ community can help create a safe space.

BE MORE CULTURALLY RESPONSIVE

In addition to wanting more welcoming physical environments and experiences with staff, other feedback requested culturally responsive material and providers. Participants expressed the need to have access to services in Spanish and with providers that understand the Latino culture and can connect with their clients on a personal basis. One individual shared, “I’m now in treatment and receiving medication only for my depression. I need and have requested counseling/therapy but the person that has called me speaks English only. The medication by itself is not helping; what has really helped me get better is participating in CCA (Center for Community Advocacy). CCA actively engages us and when I started to engage in other things in my community, I started to get better.” Another individual stated, and “we tried to use the Critical Incident Stress Management team and it took a long time to find someone who spoke Spanish.”
INVEST IN PREVENTION WITH DIVERSE SUPPORT NETWORKS AT THE COMMUNITY LEVEL

Community members emphasized the importance of prevention and having access to the right conditions in their neighborhoods to support their mental health. Participants underscored the importance of intervening early before people develop signs and symptoms of a mental illness and before it becomes serious. Some of the participants suggested activities that would support their mental health and their wellbeing which are not traditional mental health services.

As much as group participants felt clinical environments could be improved, there was more frequent mention of the need for services being more embedded within the community. Participants felt that locating services in community settings where people naturally gather is desirable because there are lower levels of stigma there than at a mental health clinic. One participant shared, “something that has helped me a lot is when the physicians from Natividad Medical Center come to the community and facilitate conversations on how to deal with stress, anxiety, depression. It’s important and we need to talk about mental health.”

Providing services at locations that are accessible for community members also helps remove the barrier of transportation to get to services, especially for older adults and people who do not own a car. “We come to this group because we like it. We talk, sometimes we are worried about something and we let it out here, we laugh, and we release the stress. Most of us don’t drive anymore so it’s convenient that the support group happens here where we live.” Another felt that “our mental health needs are related to our ability to be connected to people. Our inability to drive increases our isolation and plays with our emotional state and increases our risk for depression over our sense of isolation and dependency from others.” Yet another said “we have challenges getting [to this group]. I’m fortunate that I can walk to the group but others come from Salinas or Soledad and get rides here. I feel strongly that there is a great need in the Hispanic community that is not being met. They do not have the services like the Blind and Visually Impaired Center available in their community.”

Support groups were a popular strategy identified in the Focus Groups to get mental health service messaging and treatments more embedded in the community. One individual said, “More free platicas/dialogues and support groups are needed on a regular basis at schools and the community. It would be great if MCBH develops relationships with the community engagement coordinators at schools and other community settings to provide these dialogues and support groups. These dialogues and circles of support create camaraderie, trust, and are beneficial to people’s healing and personal growth.” Adult participants shared, “What would really help us are yoga, Zumba, dance, and nutrition classes during times that are convenient when we work, after 6pm.” Another said,
“People are going through difficult situations on their own. Support groups and counseling could help give some relief to the community. When they are available, promote/market them to the community.” Youth participants shared that what can keep them emotionally healthy and prevent mental illness is engaging in things like “sports, skating, riding their bike and having access to parks and safe spaces such as game rooms, trampoline space, art rooms, skate parks.” They also expressed that having a support system and “being with their homies” is protective.

The Focus Groups also revealed the level of stress that violence and gangs in the community is placing on individuals and families. Community-level support groups would help combat levels of stress, anxiety and isolation. A feeling of unsafety in their neighborhoods was a common theme among the participants in King City, Castroville, and East Salinas. Participants described feeling unsafe as one of the barriers that discourages them to walk outside, use parks, and becoming active in their neighborhoods. A youth participant from East Salinas said, “I feel that in general you can’t go out here in Salinas, even if we have the resources because we do not feel safe. There is a recreational place close to my house but I honestly do not go because I do not feel safe.” A Castroville participant backed this up by saying, “We’re concerned about the violence in this community. There are frequent shootings. We think it’s gang-related. People say that it’s true that Castroville is a “pueblo chico, infierno grande”, [meaning] “small town, big hell.” Another in King City said, “we’re really worried about the violence in this community. There is a shooting almost every other day. We hear the gunshots everywhere. We think it’s gang-related.”

HELP REDUCE STIGMA, PROVIDE EDUCATION ABOUT MENTAL HEALTH AND SERVICES AVAILABLE IN THE COMMUNITY

The stigma associated with mental health was frequently cited by community members as preventing them from accessing mental health services. Participants emphasized the importance of education and outreach as a strategy to decrease stigma and increase awareness of the supports and treatments available for mental illness. “There is still stigma associated with mental health. We’ve noticed that when we use the word “counselor” instead of “psychologist” more people are interested in using the services. People think that psychologists are for the severe mentally ill,” stated one participant. When asked “why do they think people don’t seek help for mental health issues?” youth participants responded that “the rejection of the idea about having a mental health issue”; “not being able to accept it or denying it”; “cultural stigma and not wanting people to think that I’m crazy”; and “not knowing where to go for help” are some of the reasons preventing them from accessing mental health services. Older adult participants cited stigma as one of the biggest barriers to seeking mental health services. “People have shame or pride. They say that they’re not sick, that they’re healthy but they moan or lament themselves too much.” They cited shame as the main reason why some older adults do not use mental health services and the support group available to them at their housing complex.

The comments from participants suggest that more education on mental health as part of a person’s overall health and wellbeing is needed to destigmatize and normalize it. The public also needs education on what
services are available and how they can access them. As one participant observed, “It’s important to keep funding outreach. I think there are more people who are having trouble finding someone to talk with, I found help through a church. There is a lot of homelessness and people who don’t know who to go to.” That said, cost of services is also a concern, reflected by this statement: “We need free or low cost activities such as art classes, sports, and other recreational activities to keep the youth from this community engaged. We don’t have a YMCA, a Boys & Girls Club, etc. The City of King City offers some sports but they are not free and they are not affordable for a family who must pay for more than one youth. There are families that have up to four children.”

CONCLUDING THOUGHTS

Monterey County Behavioral Health has declared its unwavering commitment to increase services to Latinos. Findings from these Focus Groups can help us understand some of the barriers, perceptions, and experiences that prevent or encourage the Latino community to use mental health services. These Latino community members offered practical solutions that would improve their experience accessing mental health services and recommended that services become more welcoming, more culturally responsive, located in community settings more readily accessible, and that services shift towards outreach, education, and prevention. Feedback gathered from the Focus Groups have helped inform the funding strategy for this FY18-20 MHSA 3-Year Program and Expenditure Plan to increase the utilization of Behavioral Health Services to underserved Latinos who are eligible but are not currently accessing mental health services.

CPP PROCESS PHASE 2: UNDERSERVED COMMUNITIES (BY ZIP CODE) SURVEY

Another component of the CPP process for this FY18-20 MHSA 3-Year Program and Expenditure Plan was the administration of a survey in underserved communities where a majority of Latinos reside. In our continual effort to improve and expand services to Latino residents and achieve our health equity goals in Monterey County, MCBH administered a survey in the 10 county zip code areas with the greatest factor of high Latino residents and low service penetration rates. The goal of the survey was to uncover how access and quality of services can be improved in ways that would generate greater engagement of these underserved communities. The survey (Appendix III) was intended for the public “out in the real world,” provided in both English and Spanish languages, and used culturally appropriate and non-stigmatizing language and instructions. All survey administrators were Spanish-speaking or bi-lingual. The survey did not request any personal or medical information. Surveys were administered at churches, markets, schools and even door-to-door in the more rural communities. Surveys were administered by MCBH staff, as well as our community partners, the Center for Community Advocacy and enLACE. The zip code areas surveyed and the number of respondents from those locations are listed in Figure 12. A total of 214 individuals responded to the survey.
The administration of this survey was successful in reaching the population of focus, as practically 100% of respondents were Latino. The single non-Latino respondent identified as Asian. Eighty-percent (80%) of respondents used the Spanish language, while 4% used indigenous languages and 16% used English. MCBH bi-lingual staff translated the open-ended responses written in Spanish and indigenous languages. Additionally, the majority of respondents were female (68%) and between the age of 25 and 59. Older Adult and TAY populations equally comprised the remaining age demographics of respondents, and no youth under the age of 15 participated in the survey.
COMMUNITY FEEDBACK FROM SURVEYS

The first question asked respondents to select, from a list of locations, where they would feel most comfortable receiving services if they had a mental health or alcohol/drug concern. Multiple selections were allowed, and the data displayed in Figure 13 reflected the frequency of the selections per location.

The most frequent selection of comfortable places to receive services was at a Mental Health Clinic. This came as a surprise to MCBH staff, as the open-ended responses in this survey indicated a level of stigma associated with Mental Health Clinics. Primary Care Doctor facilities were close behind as the second-most preferred location for receiving services. It was perceived by MCBH, through review of open-ended survey remarks, that co-located facilities would be convenient as well as have a level of trust and confidentiality respondents associate with primary care doctors. Receiving services at Home was the third most preferable service location, likely due to the inherent convenience and privacy. Community Centers were identified as more preferable than Church or School as a service location. Several open-ended remarks expressed very favorable opinions of community centers (including libraries) as service locations due to the frequent visits to these locations with their children. Upon review of open-ended comments, it appeared stigma associated with seeking and receiving mental health services may explain Church and School being the least popular choices. In total, these responses support MCBH objectives to address stigma and increase the accessibility of services in Mental Health Clinics and co-located health facilities.

FIGURE 13: WHERE WOULD YOU FEEL MOST COMFORTABLE RECEIVING SERVICES?

- Mental Health Clinic
- Primary Care Doctor
- Home
- Community Center
- Church
- School

0 20 40 60 80 100

147 | Page
The second survey question asked the respondent to rank their preference in service availability timeframes. Responses to this ranking question can be found in Figure 14. Respondents were asked to rank the four options in order, with a score of 1 being the most preferred appointment timeframe and 4 being the least preferred. After work (5pm-8pm) and during the day (8am-5pm) were equally preferred as the most favored service appointment times; however, after work hours remained the more preferred choice overall. Receiving services over the phone or computer was by far the least preferred option, as the majority of respondents ranked it last. Receiving services on the weekend was more frequently the 2nd or 3rd choice, indicating that it is not the most ideal timeframe, but may still offer a level of convenience for working individuals.

![Preference of Service Appointment](image)

The third and final question of this survey allowed for open-ended input on how respondents believed MCBH could better serve them, their families and communities. A total of 181 comments were received. MCBH staff analyzed this qualitative data for themes related to community needs and recommendations for service improvement. The frequency of themes appearing in responses were then tallied for quantitative assessment.

**ACCESSIBILITY OF SERVICES**, expressed in various forms, was the most predominant topic addressed in the survey responses. Half of all comments received addressed some aspect of “accessibility of services”, meaning they were unaware of services, could not physically access services or navigate the system, or did not think services were appropriate for them. Over a quarter of all respondents expressed an interest in learning more about what defines mental health issues and what services are available. This interest was expressed in questions like “Where are services located and who can be referred to services?” and many requests for workshops and sessions on mental health to be conducted in their community, churches, libraries and schools. A few respondents requested more education and training so they may volunteer as a type of system navigator in their community. Many comments requesting for more information expressed an immediate need, most frequently citing issues with drugs or alcohol.
LACK OF TRANSPORTATION was the second more frequent point of feedback. Proximity to services presents a major challenge to individuals who cannot drive, despite MCBH and other community providers having clinic locations in the larger towns of each region. One in ten respondents requested free transportation or bus vouchers to access services, while another ten percent (10%) requested services be integrated a more dispersed network of community facilities like libraries, schools and community centers. Several others asked for services to be integrated with physical health care providers for greater convenience.

NOT FEELING WELCOMED TO ACCESS SERVICES was another overarching theme related to accessibility. More specifically, about ten percent (10%) of Spanish speaking individuals were unaware of or did not think sufficient Spanish language services were available. A few respondents noted illegal immigration status and therefore would not pursue services, while a few other requested services be brought to the fields for the migrant farmworker population. Confusion or concern over costs and insurance, or lack thereof, was another reason that fifteen percent (15%) of respondents would not pursue treatment services. Eight percent (8%) of responses indicated stigma associated with mental illness as a prohibitive factor as well.

Recommendations and requests for various services or service enhancements were also provided by respondents. The occurrence of feedback on prevention related topics and treatment focused topics was evenly split. Most interest in services for children was focused parenting education and family supports. Many respondents noted the challenges of relating to their children or grandchildren, and the difficulty of communicating with them about drugs, gangs, divorce and the disconnection they feel with their children being so engaged with their phones and technology. Those interested in services for adults most frequently cited anxiety and depression as ailments and the most frequently requested services were community- and physically-oriented prevention activities like group Zumba, yoga and sports in local parks. Drug and alcohol abuse was also a frequently cited concern, with seventeen percent (17%) of respondents wanting assistance with prevention or treatment services for drug or alcohol abuse.
CPP Process Phase 3: 30-Day Public Review and Comment Period

In support of the CPP process and in compliance with MHSA regulations, a 30-day public review and comment period is being conducted beginning Wednesday, August 23 through Wednesday, September 21, 2017 to invite input and feedback on this draft FY18-20 MHSA 3-Year Program and Expenditure Plan. A copy of the draft plan document, in English and Spanish, will be posted on the MCBH website (MTYHD.org). Copies will be available for reviewing in hard copy format at the MCBH Administrative Offices located at 1270 Natividad Road in Salinas, at MCBH clinics, and at Monterey County Library locations throughout the County. An announcement of the 30-day public review and comment period will be made via press release and email to community stakeholders, and posted on Face Book and Twitter.

Following the 30-day review and comment period, on September 28, 2017, the Mental Health Commission will conduct a Public Hearing on this draft FY18-20 MHSA 3-Year Program and Expenditure Plan, receive a Summary of Public Comments submitted (which will appear as Appendix IV in the final version of the Plan document), and make a recommendation for approval and adoption by the Monterey County Board of Supervisors.
WHAT DID WE DO:
REVIEW OF FY15/16
MHSA PROGRAMS
Prevention & Early Intervention

Children’s System of Care – Prevention Programs

EPICENTER

<table>
<thead>
<tr>
<th>MHSA Component</th>
<th>PEI - Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>TAY</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>TAY (16-25)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Monterey County Transition Age Youth “TAY” (ages 16 to 25) who are currently transitioning from the various systems of care in Monterey County (Child Welfare System, Mental Health System and Probation System), and other at-risk youth as defined by The Epicenter.</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>The Epicenter</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Salinas</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>456</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$191</td>
</tr>
</tbody>
</table>

Program Description

The Epicenter serves underserved TAY populations in Monterey County, including current/former Foster Youth, LGBTQ Youth, and other “systems of care” youth by connecting them to community resources in four (4) major pillars (Education, Employment, Housing/Living Stability and Health and Wellness). The Center provides drop-in appointments, a variety of experiential learning opportunities such as workshops, and special events, along with referrals and access to a variety of services that support independent living skills, including peer support, information and referral, food, computer access, job boards, resources and connections to a multitude of co-located services that youth may not access otherwise. The Epicenter also provides comprehensive case management to identify, establish and work toward the achievement of a Life Plan for youth who are disengaged from services, are homeless, or are experiencing significant challenges to independence. A youth leadership team has also been developed to provide leadership and feedback related to better serving individuals who identify as LGBTQ.

Program Goals and Evaluation Methodology

The goal of the Epicenter is to increase youths’ independent living skills and knowledge so they may reach self-sufficiency. Program outcomes and youth participants’ progress in the domains of Education, Employment, Housing/Living Stability and Health and Wellness are assessed and tracked by Epicenter staff and are monitored using the Efforts to Outcomes data system.

Service Data and Impact on Health Equity

In FY16, the Epicenter served 456 clients, which exceeds the contracted amount of 250 youth by 206. Of clients served in FY16, 62% were Latino. This figure represents a modest contribution towards meeting our
health equity goals in Monterey County, with racial equity figures being below the goal of 75% Latino engagement. Regarding regional equity goals in South County, this program provided support groups but does not have a physical location where services can be accessed on a regular basis.

While the Epicenter is located in Salinas, there has been a concerted effort to provide LGBTQ supports in South County. Over the past 3 year MHSA Plan period, the program provided presentations to South County middle and high schools reaching 34 youth of which 85% were Latino. The services that the Epicenter is providing to LGBTQ youth and the training that is being provided to the community to raise awareness and increase sensitivity regarding LGBTQ issues represents a strong impact in decreasing health disparities to individuals who identify as LGBTQ.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 24% of the total budget of $358,000. Other funding includes grants, private donations and Monterey County Department of Social Services dollars. This program is demonstrating positive contribution towards meeting the health equity goals of Monterey County, specifically in providing services for the LGBTQ population.
CHILDREN’S SYSTEM OF CARE – EARLY INTERVENTION PROGRAMS

PROGRAM NAME: KINSHIP CENTER SOUTH COUNTY CLINIC

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>PEI - Early Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>Early Childhood Intervention</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Children &amp; Youth (0-15)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Children or youth in or transitioning to permanent placements, ages birth to 21, with moderate to severe emotional and/or behavioral disturbance.</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>Kinship Center / Seneca</td>
</tr>
<tr>
<td>Service Location:</td>
<td>King City</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>61</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$7,077</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

The South County (King City) Clinic operated by the Kinship Center provides outpatient mental health services to eligible children and their families in the southern portion of Monterey County. The services are focused on promoting the mental health of children whose social and emotional well-being has been negatively impacted by loss and trauma associated with poor family functioning, abuse, neglect, domestic violence, parental incarceration and parental substance abuse. Mental health services refer to those individual, family or group therapies and interventions that are designed to reduce the incidence and risk of mental health disabilities, and improve and maintain functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency. These services are also intended to reduce the possibility of future residential care, periodic inpatient hospitalization, placement at out-of-state facilities, or placement in a juvenile justice facility.

Kinship Center staff use their expertise in permanency, child development, attachment and trauma to provide effective mental health treatment and support the well-being of the entire family. Significant work is done with caregivers in collateral parenting sessions to help caregivers understand the unique needs of children who have been exposed to trauma and multiple transitions, and to develop successful interventions to support these children.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goals of this program are to 1) reduce the child’s mental health symptoms, improve the child’s overall functioning, and address specific permanency, loss, and trauma issues that impact the mental health functioning of the child and the family; and 2) increase parent/caregiver awareness and skills to support children’s healthy development. Progress towards achieving the above goals are assessed by clinical case managers, with health outcomes and key events monitored using the Avatar electronic health record system and administering pre and post tests. Additional evaluation methodology to be addressed by the
program within this 3 year plan period shall include utilizing the CANS and The Parenting Stress Index (or comparable standardized parenting assessment outcome tool to be decided in coordination with the County).

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the South County Clinic in King City served 61 clients. Of clients served, 91% were Latino and 100% were from South County. When combined, these figures represent a very positive contribution towards meeting our health equity goals in Monterey County, with racial equity figures being above the goal of 75% Latino engagement and regional equity figures being above the goal of 20% engagement of South County residents.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 45% of the total program budget. The program also leverages Medi-Cal, and 92% of those individuals served were Medi-Cal beneficiaries. This program provides services to children and young adults which are directly in line with the MCBH Strategic Plan.
PROGRAM NAME: MCSTART 0-5 & EXPANSION

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>PEI - Early Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area</td>
<td>Early Childhood Intervention</td>
</tr>
<tr>
<td>MHSA Age Group</td>
<td>Children &amp; Youth (0-15)</td>
</tr>
<tr>
<td>Priority Population</td>
<td>Infants or children, ages 0 to 5 years of age with severe social and emotional developmental delays or disturbances caused by early childhood trauma and/or exposure to alcohol and other drugs. Children ages 6-11 years of age with open child welfare case of documented history of child abuse or neglect.</td>
</tr>
<tr>
<td>Service Provider</td>
<td>Door to Hope</td>
</tr>
<tr>
<td>Service Location</td>
<td>Salinas</td>
</tr>
<tr>
<td>Languages served</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16</td>
<td>522</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16</td>
<td>$3,826</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

MCSTART is a collaborative early intervention program with Door to Hope as the lead agency. The program provides services for infants and children experiencing developmental delays and mental health problems caused by early childhood trauma, including neglect, abuse, violence, and/or prenatal exposure to alcohol and other drugs. The primary focus is to identify, assess, refer, and treat infants and children affected by the broad spectrum of developmental, social, emotional, dyadic, and neurobehavioral disorders utilizing evidence-based practices and trauma-informed services. To ensure these high-risk children are physically healthy and mentally stable, treatment services provided through McStart include health assessment, case management and linkage, rehabilitation, therapy, and other collateral treatment. The physical health components of the program allow for a comprehensive health approach to care however, these specific services are not part of the mental health program service array. Mental health services refer to those individual, family or group therapies and interventions that are designed to reduce the risk and incidence of mental health disabilities and improve and maintain functioning.

PROGRAM GOALS AND EVALUATION METHODOLOGY

Goals of the MCSTART program include improvement of the child’s development and health, reduced mental health symptoms, increased school readiness, improved family functioning, and the reduced possibility of future residential care, out-of-the-home placement, and/or hospitalization. Outcomes related to development, enhanced self-regulation, and learning are currently tracked through the Ages and Stages Questionnaire. Additional evaluation methodology to be addressed by the program within this 3 year MHSA plan period shall include utilizing the CANS and a standardized trauma symptom measure (the specific outcome tool to be decided in coordination with the County) to evaluate mental health services outcomes. This program uses the Avatar electronic medical record system.
SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the MCSTART 0-5 & Expansion served 522 clients. Of clients served, 54% of were Latino and 15% were from South County. Latino services represent a modest contribution toward meeting our health equity goals in Monterey County, with a racial equity goal of 75% Latino engagement. The services provided to South County residents represent a moderate contribution toward meeting our regional equity goal of 20% engagement of South County residents.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 47% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. The MCSTART program has demonstrated the ability to provide mental health services that are billable to Medi-Cal; however, an internal Quality Assurance audit found potential audit exceptions. Moving forward, this program must consistently demonstrate the capacity to provide adequate documentation in compliance with Medi-Cal billing requirements for specialty mental health services.
PROGRAM NAME: PAJARO VALLEY PREVENTION AND STUDENT ASSISTANCE

MHSA Component – Service Category: PEI - Early Intervention

MCBH Strategic Plan Service Area: Student Mental Health

MHSA Age Group: Children & Youth (0-15)

Priority Population: Monterey County children and their families attending schools in the North Monterey County area (Pajaro/Las Lomas) area who are Medi-Cal eligible and who require mental health services

Service Provider: Pajaro Valley Prevention and Student Assistance

Service Location: Watsonville/Castroville

Languages served: English and Spanish

Number of Clients Served in FY16: 117

Cost Per Client Served in FY16: $2,444

PROGRAM DESCRIPTION

Pajaro Valley Prevention and Student Assistance (PVPSA) serves Monterey County children and their families attending schools in the North Monterey County area (Pajaro/Las Lomas) who are Medi-Cal eligible and require mental health services. This student counseling program provides access to services for an unserved and often underserved population that resides in the most northern region of Monterey County. PVPSA is the only Medi-Cal certified mental health provider in this geographic area. A dedicated PVPSA office is found in each school served and the mental health counselor participates as a key member of the school team. The mental health counselor provides a family therapy approach to services and engages caregivers/parents as needed to ensure progress in their respective treatment goals. Due to the geographic location of these communities and limited public transportation, there may be transportation barriers to accessing psychiatric services for children who may require them. PVPSA hired a bilingual/bicultural case management specialist to support counselors with providing transportation and linkage to support services as needed.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of the MHSA funded PVPSA school counseling program is to provide children with developing coping skills in order to manage their impairment(s) and be able to function in day-to-day life and overall academic performance. Based on the current PEI logic model for the program, the CANS is to be utilized by PVPSA clinical staff to evaluate client progress and program outcomes. Additional evaluation methodology to be addressed by the program within this 3 year MHSA plan period shall include utilizing the CANS-EI to measure and monitor outcomes. Records are maintained using the Avatar electronic medical records system.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Pajaro Valley Prevention and Student Assistance served 117 clients. Of clients served, 95% of were Latino. This program is specifically designed to provide services in the Pajaro region of Monterey
County and therefore, by design, would not provide services within the South County region. The program is doing an excellent job at serving the Latino population, with racial equity figures exceeding the goal of 75% Latino engagement.

**SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY**

In FY16, MHSA funds accounted for 66% of the total program budget. PVPSA also expanded the program’s capacity to provide 100% Medi-Cal reimbursable services by adding benefits eligibility assistance to its array of services. This program has demonstrated a strong positive contribution towards meeting the racial health equity goals of Monterey County.
PROGRAM NAME: SCHOOL BASED COUNSELING

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>PEI - Early Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>Student Mental Health</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Children &amp; Youth (0-15)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Monterey County school age children who suffer from trauma and related issues due exposure to domestic and other violence</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>Harmony at Home</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Alisal Union School District, Salinas Elementary School District and Salinas Union High School District</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>393</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$2,010</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

Harmony At Home’s “Sticks & Stones” School-Based Counseling Program is a prevention program for children exposed to violence and trauma in Monterey County. Domestic violence that occurs in families of school age children leads to unhealthy psychological development of children. This program offers 10-week group counseling sessions in selected schools in the Alisal Union, Salinas Elementary and Salinas Union High School Districts, in collaboration with Monterey County Office of Education, MCBH and other community partners. Additional program activities include outreach and engagement activities conducted with community groups and organizations to further promote the program and availability of services. These activities will lead to partnerships that will increase referrals and participation of families or parents/caregivers of children who have experienced trauma as a result of witnessing domestic or community violence. This program also provides clinical supervision for up to four (4) CSU Monterey Bay Master of Social Work (MSW) program student interns. These student interns provide counseling in schools to children and families/caregivers, providing an enhanced level of services. This activity also provides student interns with real world experience providing clinical services in underserved communities.

PROGRAM GOALS AND EVALUATION METHODOLOGY

Goals of this program include providing short-term intervention focusing on reducing stigma surrounding domestic violence, mental illness and those who access mental health services, while also improving child and family functioning. Additional evaluation methodology to be addressed by the program within the 3 year MHSA plan period shall include utilizing the CANS-EI to measure and monitor outcomes. The program does not currently utilize the Avatar electronic health records system.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Sticks & Stones School Based Counseling program served 393 clients. Of clients served 90% of were Latino and none were from South County. Although the demographic data shows the Program
has exceeded the goal of 75% Latino engagement, regional equity data is well below the goal of 20% engagement of South County residents, as the partner school districts are located solely in Salinas.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 12% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources.
PROGRAM NAME: ARCHER CHILD ADVOCACY CENTER

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>PEI - Early Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>Involved in Social Services</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Children &amp; Youth (0-15)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Sexually exploited and abused children are the focus of this program</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>MCBH</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Salinas</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>101</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$87</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

The Archer Child Advocacy Center, a program of Natividad Medical Center (NMC) Pediatrics, was established to provide a child-friendly central location for forensic interviews where there are allegations of child sexual exploitation and abuse. Children’s Behavioral Health (CBH) provides mental health risk and treatment needs assessment, crisis stabilization, psychoeducation, linkage or provision of mental health treatment services as needed. The therapist can also provide mental health psychoeducation to the non-offending parent of a suspected child victim to ensure that the mental health needs of the child are addressed after the forensic interview.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The CBH Archer Child Advocacy Center program’s goals are to increase early detection/identification of mental health needs for victims of child sexual abuse and linkages to services; increase help-seeking and utilization of services by children who have received forensic interviews due to allegations of child abuse; reduction of risk symptoms and improved recovery for children after sexual exploitation experiences and participation in forensic interviews regarding those events. Evaluation of program goals will be conducted through review of administrative data including number of clients screened, number of referrals made, and number of service engagements. Additionally, clients that do receive mental health treatment through MCBH as part of this program will have outcome data assessed through the CANS and the Avatar electronic medical records system.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Archer Child Advocacy Center served 101 clients. Of clients served, 67% of were Latino and 11% were from South County. However, when evaluating equity in this program it is important to consider that the individuals served are limited to those referred to the Center for services.
SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 63% of the total program budget. This program is also funded through several community partners including NMC, Department of Social Services, and the Rape Crisis Center.
**PROGRAM NAME: KINSHIP CENTER D’ARRIGO CHILDREN’S CLINIC**

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>PEI – Early Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>At Risk of Placement</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Children &amp; Youth (0-15)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Children and families touched by adoption, foster care, relative caregiving or legal guardianship</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>Kinship Center</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Salinas</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>184</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$7,525</td>
</tr>
</tbody>
</table>

**PROGRAM DESCRIPTION**

The Kinship Center D’Arrigo Children’s Clinic provides outpatient mental health services to eligible children and their families. Mental health services refer to those individual, family or group therapies and interventions designed to provide reduction of mental disability and improvement and maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency. The clinic also provides mental health services, medication support and case management/brokerage to youth who require outpatient services. The focus of the program is permanency for children, lessen the impacts of adoption on a child and his/her family, as well as the impacts on children being raised by a relative caregiver. Such services help reduce the possibility of future residential care, periodic inpatient hospitalization, placement at out-of-state facilities, or placement in a juvenile justice facility.

**PROGRAM GOALS AND EVALUATION METHODOLOGY**

The goal of the D’Arrigo Children’s Clinic is to provide outpatient mental health services to eligible children and their families in order to improve the child’s overall functioning, support the child’s parent/caregiver, improve the family’s well-being, and address specific permanency issues that impact the life of the child and his or her family. Outcomes associated with this program include improvement in the child’s functioning within his/her family, school, peer group and community, support and empowerment of the child’s parent(s)/caregiver(s) by providing skills and strategies to provide continuity of care, and a reduction in the volume and level of parental stress as demonstrated by pre and post-tests.

**SERVICE DATA AND IMPACT ON HEALTH EQUITY**

In FY16, the D’Arrigo Children’s Clinic served 184 clients. Of clients served, 68% of were Latino and 34% were from South County. Taken together, this program has made positive contributions towards health equity goals as it’s approaching the goal of 75% Latino engagement and regional equity figures have exceeded the goal of 20% engagement of South County residents.
SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 11% of the total program budget. The D’Arrigo Children’s Center has done well to leverage MHSA funds with Medi-Cal billing and other sources.
PROGRAM NAME: KINSHIP CENTER TRAUMA SERVICES PROGRAM

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>PEI - Early Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>At Risk of Placement</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Children &amp; Youth (0-15)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Young children exposed to trauma</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>Kinship Center</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Salinas</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>data included in D’Arrigo Children’s Clinic</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>same as above</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

Kinship Center’s Trauma Services Program provides outpatient mental health services to eligible children 0-5 and their families. Mental health services refer to those individual, family or group therapies and interventions that are designed to provide reduction of mental disability and improvement and maintenance of functioning consistent with the goals of learning, development, future independent living and enhanced self-sufficiency. The focus of the program is resolving trauma experiences for children, the impact of trauma on a child and his/her family, and the impact of trauma on children being raised by a relative caregiver. Such services help to reduce the possibility of future residential care, periodic inpatient hospitalization, placement at out-of-home facilities, or placement in a juvenile justice facility.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The primary goals of this Trauma Services Program are to improve the child’s overall functioning, improve the family’s well-being and reduce familial stress by addressing specific trauma issues that impact the life of the child and his or her family as well as develop parental skills using evidence informed reflective parenting. Intended outcomes are improved measures of functioning of the child within their family, preschool, peer group and community, as well as a reduction in the volume and level of parental stress as demonstrated by pre and post-tests.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Trauma Services Program data was included in the D’Arrigo Children’s Clinic program. Of clients served, 68% of were Latino and 34% were from South County. Taken together, this program has made positive contributions towards health equity goals as it’s approaching the goal of 75% Latino engagement and regional equity figures have exceeded the goal of 20% engagement of South County residents.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 8% of the total program budget. The Trauma Services Program has done well to leverage MHSA funds with Medi-Cal billing and other sources.
PROGRAM NAME: PREVENTION AND RECOVERY IN EARLY PSYCHOSIS (PREP)

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>PEI - Early Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>TAY</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>TAY (16-25)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Monterey County residents ages 14-35 experiencing early onset (within 5 years) of psychotic symptoms</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>Family Service Agency of San Francisco dba Felton Institute</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Salinas</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>54</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$9,259</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

The Prevention and Recovery in Early Psychosis (PREP) Monterey program provides an integrated package of evidence-based treatments designed for remission of early psychosis among individuals age 14-35 who are demonstrating symptoms and functional impairments related to early psychosis and/or diagnosis of Schizophrenia or Schizoaffective Disorder. There is strong evidence for this array of treatments in promoting positive outcomes for people struggling with early psychosis, and collectively they address the impact of psychosis in multiple areas of functioning. The core services include individual psychotherapy (Cognitive Behavioral Therapy for Psychosis - CBTp), strength-based case management, algorithm based medication management, Multifamily Groups (MFG), and educational and vocational support. PREP is the primary coordinated specialty care program for early psychosis in the County of Monterey. In 2013, PREP began providing services in Monterey County funded by the Center for Medicare and Medicaid Services (CMS). After the Federal Grant ended in June 2015, PREP was able to sustain the program with MHSA and Medi-Cal billing.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The program aims to improve the mental health and level of functioning for individuals who have experienced onset of psychosis within the past five years. Individual mental health outcomes, family engagement and key events like psychiatric hospitalizations, crisis/Emergency Department visits, finding employment and housing are assessed and tracked by a case manager. The PREP program has a robust evaluation component and includes cost savings projections based upon decreased hospitalization utilization and unplanned mental health services for clients who served in the program. The program does not currently utilize the Avatar electronic health record system to track health outcomes and key treatment elements. PREP has been requested to participate in Avatar documentation and it will remain an evaluation methodology improvement request during this 3 year MHSA plan period.
SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, PREP served 54 clients. Of clients served, 57% were Latino and 20% were from South County. Though located in Salinas, this program has done well to serve clients who reside in South County.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, the total contract amount for the PREP program was $500,000 of which $250,000 was funded under MHSA PEI and $250,000 was to be generated from Medi-Cal billing. In FY16, the PREP program provided a total of $393,810 in services. Difficulty of recruiting and retaining staff likely contributed to this underutilization of the annual contract funds.

MCBH values the ability of programs to leverage resources and secure sustainable funding sources. The PREP program has demonstrated the ability to provide mental health services that are billable to Medi-Cal, however an internal Quality Assurance audit found potential audit exceptions. The contractor was made aware of the audit concerns and has instituted a plan of correction. Moving forward, this program must consistently demonstrate the capacity to provide adequate documentation in compliance with Medi-Cal billing requirements for specialty mental health services. Within this 3-Year MHSA plan period, seeking alternative and complimentary funding sources will remain an objective of this program and the SAMHSA Federal Block grant funds for First Episode Psychosis treatment should be explored.
PROGRAM NAME: SEASIDE YOUTH DIVERSION PROGRAM

MHSA Component – Service Category: PEI - Early Intervention

MCBH Strategic Plan Service Area: Juvenile Justice

MHSA Age Group: Children & Youth (0-15)

Priority Population: Youth from Seaside middle schools and high schools, 10-17, make up this target population

Service Provider: MCBH

Service Location: Seaside

Languages served: English/Spanish

Number of Clients Served in FY16: 18

Cost Per Client Served in FY16: $1,420

PROGRAM DESCRIPTION

The Seaside Youth Diversion Program is a collaborative partnership between Seaside Police Department, Monterey County Probation, and MCBH. This program receives referrals from the Seaside Police Department in collaboration with the Monterey County Probation Department who identify first time offenders and/or youth, in the Seaside area, that are demonstrating first signs of emotional/behavioral issues that are affecting their education, family, and/or social well being. The purpose of the Seaside Youth Diversion Program is an attempt to identify and treat the underlying mental health issues that may lead to more complex problems within the community and contribute to the youths’ later involvement in the Juvenile Justice System. This program originally began as a pilot project to address the lack of prevention resources to the children, adolescents and transition age youth in the Seaside/Peninsula region of the County. Over the years, this program has become a successful service that has continued to be sustained through MHSA funds, Medi-Cal billing and grant funds.

PROGRAM GOALS AND EVALUATION METHODOLOGY

Goals of this program include ongoing coordination of community resources, promoting healthy family environments, and reducing recidivism of criminal activity, by addressing emotional and psychological needs of youth through the provision of mental health prevention and early intervention services. Mental health outcomes are monitored and evaluated by the CANS (Child Adolescent Needs and Strengths) Assessment Tool, as well as the Avatar Electronic Health Record Discharge Disposition Data. Key events such as arrests and incarcerations are monitored by Monterey County Probation.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Seaside Youth Diversion Program served 18 clients. Of clients served, 72% of were Latino. Given that 43% of all Seaside residents are Latino, this presents an opportunity for a dialogue with the collaborative partnership regarding the contributing factors to what appears to be an overrepresentation of Latino youth referred to the Program. The Youth Diversion Program is centrally located, serving youth residing in the City of Seaside and nearby Peninsula communities; therefore, an overall goal of 20%
engagement of South County residents does not apply to this program.

**SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY**

In FY16, MHSA funds accounted for 63% of the total program budget. Additionally, specialty mental health services provided to eligible clients are billed to Medi-Cal. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA plan period, seeking alternative and complimentary funding sources will remain an objective of this program.

In FY16, the Seaside Youth Diversion Program served 18 clients, which is only 72% of our annual goal of total clients to be served. The plan to reach our goal of treating 25 youth per year includes working together with our collaborative partners in clarifying the referral pathway to which referrals are to be maintained.
PROGRAM NAME: SILVER STAR RESOURCE CENTER

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>PEI – Early Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>Involved in Juvenile Justice</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Children &amp; Youth (6-15) Transition Age Youth (16-21)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Any youth at risk or with truancy issues can be served by Silver Star Resource Center</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>MCBH</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Salinas</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>37</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$2,880</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

Silver Star Resource Center is a multi agency collaborative of prevention and early intervention services. This collaborative includes: MCBH, Monterey County Probation, Monterey County Office of Education, the District Attorney’s Office, the Office of Employment Training and community agencies such as Community Human Services, and Partners for Peace, all co-located in order to make resources easier to access for youth and families. Behavioral Health services, at Silver Star Resource Center, are used to identify first time offenders and/or youth, throughout Monterey County, that are demonstrating first signs of emotional/behavioral issues that are affecting their education, family, and/or social well being. The purpose of the program is to identify and treat the underlying mental health issues that may lead to more complex problems within the community and contribute to the youths’ later involvement in the Juvenile Justice System.

PROGRAM GOALS AND EVALUATION METHODOLOGY

Goals of this program include ongoing coordination of community resources, promoting healthy family environments, and reducing recidivism of criminal activity, by addressing emotional and psychological needs of youth through the provision of mental health prevention and early intervention services. Mental health outcomes are monitored and evaluated by the CANS (Child Adolescents Needs and Strengths) Assessment Tool, as well as the Avatar Electronic Health Record Discharge Disposition. Key events such as arrests and incarcerations are monitored by Monterey County Probation.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, MCBH served 37 clients at the Silver Star Resource Center. Of clients served, 86% were Latino and 5% were from South County. Although the demographic data shows the Program has well exceeded the goal of 75% Latino engagement, regional equity data is well below the goal of 20% engagement of South County residents, likely due to the Program being located in Salinas.
SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 33% of the total program budget. Additionally, specialty mental health services provided to eligible clients are billed to Medi-Cal.
PROGRAM DESCRIPTION

The Child Advocate Program was created to intervene in the cycle of family violence, knowing that children exposed to violence in the home are less likely to be socially and emotionally ready for school. Additionally, this program exists to help children cope with toxic stress in the household. Toxic stress in children is defined as living with physical abuse, emotional abuse, neglect, exposure to violence, severe maternal depression, household chaos and prolonged economic hardship. Toxic stress is shown to cause damage to vital brain development that will largely determine a child’s physical, mental and emotional health into adulthood. The Program is staffed by one (1) full-time Probation Officer and two (2) Child Advocates who provide case management and linkage to community resources to the children and family members of those adults who are under the supervision of the Probation Department due to a criminal conviction.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of the Child Advocate Program is to assist parents in becoming capable and nurturing caretakers. The program strives to help families create healthier, stable home environments that enhance the health and safety of young children. Measurable outcomes to assess the above goals include improved individual and family functioning, improved school achievement and reduced criminal offenses.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Child Advocate Program served 308 clients. Of clients served, 87% of were Latino. Data on the residence of clients served is not available. Although this program served a high number of Latinos, children and families are referred to this Program, through the Probation Department, due to parental involvement in the criminal justice system.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 44% of the total program budget. Although this program makes referrals to mental health services as needed and works to improve overall family functioning, the use of MHSA funds to support Probation Department staff is not aligned with MHSA principles. In FY17, MCBH...
identified other funds to transfer to the Probation Department to sustain the services, while other potential sources of funds are examined for future years.
PROGRAM NAME: SENIOR COMPANION PROGRAM

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>PEI – Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>Adult Services</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Older Adult (60+)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>MCBH Clients with Psychiatric Disabilities residing in South County</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>Seniors Council of Santa Cruz &amp; San Benito Counties</td>
</tr>
<tr>
<td>Service Location:</td>
<td>South County</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>9</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$24,544</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

The Seniors Council Senior Companion Program serves Santa Cruz, San Benito, Monterey and Santa Clara Counties. The Program recruits, trains and places Senior Companions to work with clients who are homebound, live alone, with chronic disabilities, whose caregiver needs respite from their responsibilities, with mental health issues and may also be visually or hearing impaired. Senior Companions volunteer an average of 20 hours per week and assists clients to maintain independent living and achieve the highest quality of life possible. The Senior Companion Program provides a minimum of 1,900 hours of service to MCBH clients assigned to the Senior Companion Program by the South County Behavioral Health Services Manager.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of the Senior Companion Program is to assist older adult MCBH clients in avoiding hospitalization by providing companionship services to increase or maintain socialization activities and follow-through with the goals in their mental health treatment plan. During FY16, there were no formal evaluations conducted, however, anecdotal information indicates that these services are effectively providing the intended supports to MCBH clients served by the program.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Senior Companion Program served 9 clients. Of clients served, 100% of were Latino and 100% were from South County. These figures represent a very positive contribution towards meeting our health equity goals in Monterey County, with racial equity figures exceeding the goal of 75% Latino engagement and regional equity figures exceeding the goal of 20% engagement of South County residents.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 10% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources.
PROGRAM DESCRIPTION

The Senior Peer Counseling Program (SPC) provides no-cost mental health intervention and emotional support to older adults suffering from depression, anxiety, grief, loss, adjustment to chronic illness, and other stressors that can occur in the latter third of life. Peer Counselors, trained and supervised by mental health professionals, provide short-term one-on-one counseling that may be home-based, office-based, or at long term-care facilities. Volunteers and staff facilitate support groups that foster emotional support, encouragement, self-empowerment and connection to others.

Since 2008-09, with funding from the MHSA, the SPC was expanded to include bi-lingual/bicultural program services. Bilingual/bicultural volunteers were trained to provide counseling and support groups to unserved Latino older adults, mainly in Salinas. Wellness lectures were introduced throughout Salinas and South County, with an emphasis on issues related to Latino adults.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goals of the Senior Peer Counseling program are as follows: a) Provide Information, referrals and consultation; b) Provide individual and group counseling; c) Maintain an active roster of trained Volunteer Peer Counselors; and d) Provide Wellness lectures to increase the knowledge of mental health issues and available community resources.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Peer Counseling/Fortaleciendo el Bienestar (FeB) program served 438 clients. Of clients served, 56% were Latino and 3% were from South County. When combined, these figures represent opportunities for program improvements to increase Latino engagement, especially South County residents, as racial equity figures are below the goal of 75% Latino engagement and regional equity figures.
are below the goal of 20% engagement of South County residents.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16 MHSA funds accounted for 100% of the total program budget. Within this 3-Year MHSA plan period, seeking alternative and complimentary funding sources to augment existing revenues would better position this program to meet the growing population of older adults in Monterey County. In the areas of service delivery improvement, the following are the recommendations for this 3-Year MHSA plan period:

1) Continue to make expanded efforts to recruit and retain Latino volunteers; 2) Continue to make efforts to reach out to facilities in the South County to recruit volunteers; and 3) Continue to make efforts to reach out to South County locations to offer orientations to the FeB program and offer educational series at one or more sites.
PROGRAM NAME: SUCCESS OVER STIGMA

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>PEI - Stigma and Discrimination Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>Adult Services</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Adult (26-59)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Communitywide Education</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>Interim Inc.</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Salinas</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English</td>
</tr>
<tr>
<td>Number of Presentations in FY16:</td>
<td>25</td>
</tr>
<tr>
<td>Cost Per Presentation in FY16:</td>
<td>$4,010</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

The “Success Over Stigma” (SOS) program promotes consumer involvement in advocating for public policies that support and empower people with psychiatric disabilities. The program focuses on consumer involvement in planning and executing mental health services and anti-stigma messaging in the community. SOS provides peer consultation to service providers, including increasing peer involvement in developing and strengthening mental health services both locally and at the state level. Lastly, consumers learn how to better advocate for themselves by providing reciprocal peer support and advocacy in their community. This initiative gives clients the opportunity to share their behavioral health experience and impact policy regarding their services.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of this program is to directly confront stigma surrounding mental health issues by supporting those with serious mental illness in self-efficacy and exposing the community to a mental health consumer’s experience.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

Service demographic data to assess the program’s impact on health equity is not available for FY16. Moving forward, Success Over Stigma (SOS) will: a) track where presentations are being held throughout the county and report on those results; b) will increase the number of presentations held in South County; c) track the number of Latino and/or Spanish-speaking individuals attend the presentations or participate in the programs; and d) continue to increase the participation of Latino and/or Spanish-speaking individuals over the course of the next 3 year MHSA Plan period.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 100% of total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA Plan period, seeking alternative and complimentary funding sources will remain an objective of this program. In addition, the following are noted as areas for improvement: 1) Facilitate a monthly Advocacy Workshop in South County; 2) Develop at least two (2) new South County speakers; and 3) Facilitate at least six (6) presentations to
South County organizations/faith based communities.
PROGRAM NAME: NAMI FAMILY SELF-HELP SUPPORT & ADVOCACY  

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>PEI</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>Outreach for Early Signs</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Adult (26-59)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Family and Friends of People with Mental Illness</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>National Alliance on Mental Illness Monterey County</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Salinas, Coastal, South County</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>110</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$1,513</td>
</tr>
</tbody>
</table>

**PROGRAM DESCRIPTION**

This program supports and advocates on behalf of consumers, families, and friends of people with severe mental illness. NAMI’s staff and volunteers educate the community regarding the needs and challenges of individuals with mental illness in order to reduce stigma and improve clients’ quality of life.

**PROGRAM GOALS AND EVALUATION METHODOLOGY**

The goals of NAMI’s services to the community are as follows: 1) Provide phone, email or in-person support to family members, caregivers, and clients who are frequently in distress and in need of information; 2) Provide public presentations in Salinas and in South County with an emphasis on care to consumers and families; 3) Provide outreach services in South County and in Monterey, assuring improved response to callers and walk-in consumers seeking assistance; 4) Facilitate “Family to Family” and/or “Familia a Familia” education courses for family members and care providers of adults living with mental illness; 5) Facilitate “Provider Education” presentations to mental health professionals to encourage sensitivity in regards to mental illness; 6) Facilitate monthly “NAMI Connection Recovery Support Group” program for adults with a mental illness and family members; and 7) Coordinate with, assist and supplement existing programs in Monterey County that currently offer mental-health service programs to youth and seniors five times a year.

**SERVICE DATA AND IMPACT ON HEALTH EQUITY**

In FY16, the NAMI’s Self-Help Support & Advocacy Program served 1,436 individuals, and 53% were Latino. This figure indicates a need to increase outreach in the Latino Community, as this racial equity figure is well below the goal of 75% Latino engagement.

**SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY**

In FY16, MHSA funds accounted for 100% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA Plan period, seeking alternative and complimentary funding sources this program is recommended, as well as the following areas for improving service delivery and contributing to our health equity goals: 1) Continue to work on increasing presence in East Salinas and South County; 2) Increase the number of Programs offered.
in South County; and 3) Continue to provide at least two (2) days per week of services in South County.
PROGRAM NAME: FAMILY SUPPORT GROUPS

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>PEI</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>Early Intervention</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Adult (26-59), Older Adult (60+)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>The group is specifically for ages 18+ and welcomes all population groups</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>MCBH</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Marina, Salinas, King City and Soledad</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>70</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$1,602</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

The Family Support Groups program was developed in response to families in the community who were seeking additional support when mental illness is affecting their family’s functioning and quality of life. Families benefit from receiving psycho-education regarding mental illness symptoms and behaviors as well as an understanding of the resources available to their loved one, as well as to the family members. We know that the people we serve do better when their families are involved with a developed understanding of mental health and wellness as well as holding a strength-based approach to the process of recovery. The MHSA asserts the importance of incorporating the family perspective in the services provided. The groups are facilitated by MCBH staff two evenings per month for duration of 90 minutes per session in each region of Monterey County.

PROGRAM GOALS AND EVALUATION METHODOLOGY

By providing support to family members and significant others, participants of the Family Support Groups are more equipped to provide additional support and resources, contributing to the ultimate goal of enhancing their loved one’s quality of life. The goal is to educate, provide support, and connect family members to resources with the ultimate outcome of less utilization of emergency services and law enforcement resources. In addition, and more importantly when people with mental health challenges connect with their core gifts, (educational interests, work interests, fun activities, hobbies, and goals for a better life in the community) they have much better outcomes and are much happier overall.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Family Support Groups program served 70 clients. There are no demographic data available for FY 16 to assess the program’s contribution towards meeting our health equity goals in Monterey County.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 100% of the total program budget. The following strategies will be
implemented in FY18 to improve service delivery and assess the program’s ability to achieve our health equity goals: 1) increase the number of Family Support Groups held County-wide from currently two groups each month in Marina to a total of six groups held each month in Marina, Salinas, Soledad and King City; 2) Provide at least one Spanish-speaking group every month; and 3) Collect data on the number of family members that are attending as well as obtain some key demographic data.
PROGRAM DESCRIPTION

Interim, Inc. provides Wellness Navigators (WNs) for MCBHB’s Adult Services Clinics. WNs, stationed at each Adult Services clinic, are responsible for welcoming clients into the clinic while the client is waiting to meet with his/her psychiatrist or case coordinator. The WNs help support completion of intake screening tools, and help clients understand the services available to them. They discuss services that suit each client’s recovery needs and help connect him/her to community based resources that new clients need support in accessing. The WNs also follow up with a visit or phone call to continue linking clients to services.

The Peer Partners for Health is a voluntary training and peer support program focusing on clients who are either in the crisis residential program at Manzanita and/or the Natividad Medical Center in-patient unit to help them with their transition into the community after they are discharged. This program was requested by consumers through Recovery Task Force and the project plan was developed in collaboration with MCBH.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of this program is to utilize the assistance of a WN team, consisting of a peer and a family member, to connect consumers to community based follow up services in a culturally sensitive manner. The program also aims to decrease frequency of mental health crises by increasing support in the home to include symptom management skills training, education on mental health and connecting clients to community resources. WN’s services are provided for the client/consumer or family member in-person or over the phone for up to three months. WNs are provided a list of measurable tasks to work on with the referred consumer/family member by MCBHB Case Coordinators, and Mental Health inpatient unit staff. This peer support initiative plays an important role in the County’s efforts to promote mental health recovery, peer advocacy, and peer leadership. It will increase resilience, wellness and self-management of health and behavioral health; through this support, consumers will be more equipped to transition back to society.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Peer Support & Peer Partners for Health program served 51 clients. Of clients served, 39% of
were Latino.

**SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY**

In FY16, MHSA funds accounted for 100% of the total program budget. The following strategies will be implemented in FY18 to improve service delivery and assess the program’s ability to achieve our health equity goals: 1) 50% of consumers/clients will be referred to and obtain services from at least two community resource providers as a result of WN linkage. WN will document results daily on spreadsheet; 2) 75% of consumers who have had at least 8 contacts with a WN will report maintained or improved recovery. These results will be measured by survey results from the Recovery Assessment Scale (RAS); 3) Consumers will be asked to complete a “Consumer Satisfaction Survey” at exit; 4) WNs will track the types of resources provided to peers; e.g. Employment, education, recovery groups, transportation training, etc.; 5) WN will document in progress notes and in a form specifying linkages to specific services such as SEES, OMNI, AA/NA or with the development of a WRAP Plan; 6) WN will learn how to document in Avatar and bill for appropriate level of billable services; and 7) Demographic data of clients served, including their region of residence, will be compiled and reviewed to assess program’s ability to make a positive contribution to our health equity goals in Monterey County.
PROGRAM NAME: OMNI RESOURCE CENTER

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>PEI - Early Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>Adult Services</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Adult (26-59)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>The Center is open to all mental health consumers ages 18 and older</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>Interim Inc.</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Salinas</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>631</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$797</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

OMNI’s mission is to increase mental health wellness of individuals and the community by providing wellness awareness and innovative programs. The Center is a peer and family member operated facility. The Center serves to assist members in pursuing personal and social growth through self-help, socialization, and peer support groups. Additionally, the Center offers skill-building activities and tools to those who choose to become leaders among their peers to take an active role in the wellness and recovery movement through various initiatives. The Center works to help individuals find a meaningful role in their community, to gain self-empowerment, to learn advocacy and leadership skills, and to educate the public on mental health and recovery. OMNI facilitates a monthly Recovery Task Force to offer feedback to MCBH, providing the consumer perspective, needs and concerns. OMNI also offers weekly “After Hours”, a program specifically serving Transition Age Youth and young adults between the ages of 18-30.

PROGRAM GOALS & EVALUATION METHODOLOGY

The goal of this program is to create an inclusive environment where mutual support and resources are available to clients on their pathway to mental health wellness and recovery.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the OMNI Resource Center served 631 adults from throughout Monterey County. 27% of were Latino and 30 consumers served reported that they reside in South County.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 100% of the total program budget. The following strategies will be implemented in FY18 to improve service delivery and assess the program’s ability to achieve our health equity goals: 1) Provide Services to over 500 unduplicated consumers that will expand their knowledge of wellness and recovery; 2) 85% of consumers who attend the OMNI Center at least 10 times or more per year will report that they maintained or improved their mental health recovery. This will be measured by
pre- and post- self-survey results using the Recovery Assessment Scale (RAS); 3) 85% of consumers will report satisfaction with the quality of services provided. Measured by client self-report via annual “Consumer Satisfaction” survey instrument; 4) The Center will collaborate with MCBH and other community partners to increase outreach in those areas identified in the Underserved Communities (by Zip Code) Survey in an effort to increase Latino participation at the Center.
CHINATOWN COMMUNITY LEARNING CENTER - CSUMB COLLABORATIVE

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>PEI - Access and Linkage to Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>Homeless</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Adult (26-59)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>The population to be served is homeless adults in Chinatown Salinas</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>Interim Inc.</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Salinas</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>475</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$308</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

Interim continues to sub-contract this service to California State University at Monterey Bay (CSUMB) and provides oversight for CSUMB’s Chinatown Community Learning Center (CCLC) initiative. The purpose of the collaboration is to enable CSUMB to continue to offer qualified Master of Social Work (MSW) interns the opportunity to provide support for the homeless and other marginalized populations in the Chinatown neighborhood of Salinas and surrounding areas, many of whom are also struggling with mental health and addiction issues. The Community Learning Center is a resource center, and the staff provides structured learning opportunities, access to social services, and supports the development of micro-enterprise activities. Interim provides guidance on setting and meeting goals as well as monitors contract outcomes.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Chinatown Community Learning Center (CCLC) served 475 clients. CSUMB interns provided 64 hours per week of social work services to CCLC participants. Interns were onsite in Chinatown to offer supportive case management and related services to assist clients with health, mental health, employment, social security, nutrition and housing assistance. Demographic data of clients served by CCLC is not available for FY16.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 100% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA Plan period, seeking alternative and complimentary funding sources this program is recommended, as well as the following areas for improving service delivery and contribute to our health equity goals: Four (4) MSW Interns will provide services in the Chinatown Community Learning Center for four (4) days per week, serving a minimum of twenty-five (25) unduplicated homeless clients per month, providing the following services: a) facilitate two (2) groups per week employing a mental health and/or substance use disorder evidence based practice, skill building or Interim curriculum with clients; b) assist two (2) clients per month toward completion of supporting documentation necessary to begin the SSI application process; c) assist
clients in applying for General Assistance and/or Medi-Cal or other health benefits and/or Food Stamps for at least two (2) individuals with mental illness per month; d) assist 1-2 clients achieve housing and/or employment; e) provide the necessary case management and/or situational crisis counseling services to the clients on their case load; and f) provide clients with transportation to needed services whenever necessary and within the allowable guidelines of the University policy.
PROGRAM NAME: MULTI-LINGUAL PARENT EDUCATION PARTNERSHIP

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>PEI - Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>Early Childhood Intervention</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Children &amp; Youth (0-15)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Spanish speaking parents with young children</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>Community Human Services</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Marina, Salinas, Soledad, King City</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>1,092</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$164</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

The Multi-Lingual Parent Education Partnership, with Community Human Services as the lead agency, offers “Triple P”, an 8 to 10 week evidence-based curriculum for parents of children ages 2 through 12 with emotional/behavioral challenges. The program also aims to increase capacity for culturally and linguistically appropriate parent education opportunities in targeted areas of Monterey County by recruiting and training additional parent educators in this evidenced-based curriculum to ensure that the program will have capacity to serve English and Spanish-speaking families in Salinas, Seaside, South County and North County.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of this program is to increase parenting skills, particularly for Spanish-speaking parents. The main outcome measured will be the number of parents demonstrating more effective parenting skills and confidence as measured by the selected curriculum’s evaluation.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Multi-Lingual Parent Education Partnership served 652 clients. Of clients served, 86% were Latino. There was no data available on number of South County clients, although there were seven (7) “Triple P” groups held in South County. This figure represents a positive contribution towards meeting our health equity goals in Monterey County, with racial equity figures exceeding the goal of 75% Latino engagement and our regional equity goals being addressed by holding multiple activities in the South County region.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA fund accounted for 16% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA Plan period, seeking alternative and complimentary funding sources is an objective of this program. Perhaps funding options are available through Community Foundation and/or Medi-Cal Administrative Activities funding.
Increased efforts on collecting regional demographic data will be implemented as well.
PROGRAM NAME: SUICIDE PREVENTION

MHSA Component – Service Category | PEI – Suicide Prevention
--- | ---
MCBH Strategic Plan Service Area: | ACCESS Services
MHSA Age Group: | All Ages
Priority Population: | All persons at-risk of suicide
Service Provider: | Family Service Agency of the Central Coast
Service Location: | Santa Cruz (willing to travel)
Languages served: | English and Spanish, Language Line
Number of Clients Served in FY16: | 5,828
Cost Per Client Served in FY16: | $38

PROGRAM DESCRIPTION

Suicide Prevention Service (SPS) is a program of Family Service Agency of the Central Coast and has been serving Monterey, Santa Cruz, and San Benito residents since 1967. The program’s primary mission is to identify high-risk individuals, families, and groups and provide them with safe alternatives to suicidal behavior. SPS uses an integrated method of service delivery includes a 24/7/365 free, multilingual suicide crisis line, educational outreach and training, and bereavement support services for those who have lost a loved one to suicide.

Nearly everyone is touched by suicide at least once in their lifetime. In 2014, Monterey County experienced 57 suicides; the youngest was 15 and the oldest was 96. SPS staff regularly participates in local needs assessments to contribute and learn from discussions on priorities. The Monterey County Community Health Assessment (2013) reviews of mental health indicators affirm the need for continued suicide prevention and intervention activities. Local data showed there was a significant increase in suicide among residents age 45-64, especially males, and that suicide rates for females more than doubled from 1999-2001 to 2008-2010.

MHSA funds enabled SPS to successfully adapt their program to align with nationally recognized standards for best practices and to become accredited through the American Association of Suicidology. MHSA funding has allowed SPS to diversify the range of activities offered to support residents of Monterey, Santa Cruz, and San Benito counties. Outreach personnel are now trained to offer a variety of new training programs, including ASIST, SafeTalk, and Mental Health First Aid, amongst others.

PROGRAM GOALS AND EVALUATION METHODOLOGY

Suicide Prevention Service’s primary service goal is to meet the growing need of suicide crisis response of the tri-county community and provide the highest level of service delivery possible, while maintaining accreditation through the American Association of Suicidology. The program seeks to provide the community with information about suicide, dispel myths, lower stigma by normalizing thoughts and feelings, and offer tri-county residents local resources, such as our 24-hr suicide crisis line, as an alternative to suicidal behavior.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Suicide Prevention provided presentations to 5,828 residents; 62% of service recipients were
Latino and 6% were from South County. When combined, these figures represent a modest contribution towards meeting our health equity goals in Monterey County, with racial equity figures being close to the goal of 75% Latino engagement and regional equity figures being well below the goal of 20% engagement of South County residents.

**SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY**

In FY16, MHSA funds accounted for 75% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA Plan period, seeking alternative and complimentary funding sources is an objective of this program, such as exploring potential of funding from the Community Foundation and other local charitable organizations.
PROGRAM NAME: PROMOTORES MENTAL HEALTH PROGRAM

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>PEI - Outreach for Early Signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>ACCESS Services</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Adult (26-59)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Latino Communities</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>Central Coast Citizenship Project</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Countywide</td>
</tr>
<tr>
<td>Languages served:</td>
<td>Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>4,170</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$20.42</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

The Promotores Mental Health Program was created exclusively by MHSA funding to address the issue of Latinos not adequately accessing mental health services in Monterey County. This program seeks to educate the Latino community about mental health issues and remove the stigma associated with seeking mental health services, with the aid of Promotores de Salud ("Promotores"). Promotores are individuals who provide health education and support to community members and are typically from the community they serve. As a result of this existent relationship, they are particularly effective at reaching Latinos and other unserved and underserved individuals and families. The Promotores help address the multiple barriers to accessing services, such as those related to transportation, availability, culture, language and stigma. Promotores address both physical and mental health issues and in coming from a health and civil rights perspective, they assist their community to address additional issues as well. The intent of this project is to use a service delivery model that meets the cultural, linguistic and individual needs of the population of focus. A list of activities and goals has been developed and are articulated in the Quantitative Quarterly Activities and Qualitative Quarterly Report forms.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of the Promotores program is to improve mental health awareness and access to services for the unserved Latino population of Monterey County by implementing a sustainable outreach and access model that has been integrated into the service delivery model of MCBH. This program supports the recruitment and training of Promotores, who are bi-cultural paraprofessionals, who facilitate access to mental health services and provide advocacy for unserved Spanish speaking adults, children, and families. The Promotores provide community presentations in the following areas: Salinas, North County Pajaro, Las Lomas, Castroville, and Seaside/Marina area. Through one-on-one encounters, Promotores also refer individuals and families to appropriate non-mental health resources and services as are deemed necessary. The expected outcomes of this program include increased rates of access to services, a reduction in stigma, and improved mental health outcomes and functioning. Progress towards achieving these goals is monitored and assessed through the use quarterly reports. Once an individual engages in services, their progress is monitored by the Avatar electronic medical record system.
SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Promotores Mental Health Program served 4,170 participants; 76% were Latino and 32% were from South County. When combined, these figures represent a very positive contribution towards meeting our health equity goals in Monterey County, with racial equity figures exceeding the goal of 75% Latino engagement and regional equity figures being above the goal of 20% engagement of South County residents.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 100% of the total program budget, although the agency received grant funding which supports the remaining majority (90%) of their annual budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. The agency has a licensed therapist on staff, and Medi-Cal certification may be feasible to support and/or expand these therapeutic services. A California Endowment grant may also be a possible source to enhance/expand this program.
**PROGRAM DESCRIPTION**

The Latino Community Partnership is a peer-to-peer approach to address the stigma that farmworkers often face when seeking behavioral health services. This program delivers behavioral health education to this population and generates referrals to counseling services on behalf of Latinos who would otherwise remain unserved. The Center for Community Advocacy (CCA) trains farmworker leaders to provide behavioral health presentations to their peers, educating them on mental health issues and referring those who need services to MCBH.

**PROGRAM GOALS AND EVALUATION METHODOLOGY**

The intended outcomes of this program is a lessening of stigma among the farmworker community, increased numbers of referrals and access, and improved mental health outcomes among those seeking services. CCA has a holistic approach and conducts outreach to families including youth and adults. CCA also provides the community with information about how to improve physical health, mental health and how to access other community supports. Progress towards achieving the above goals are assessed by using data collection of clients reached and by client self-report.

**SERVICE DATA AND IMPACT ON HEALTH EQUITY**

In FY16, the Latino Community Partnership served 1,814 individuals, referring 23 clients to MCBH. Of participants served, 100% of were Latino and 9% were from South County. When combined, these figures represent a positive contribution towards meeting our health equity goals in Monterey County, with racial equity figures exceeding the goal of 75% Latino engagement, although regional equity figures are well below the goal of 20% engagement of South County residents.

**SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY**

In FY16, MHSA funds accounted for 100% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA Plan period, seeking alternative and complimentary funding sources will remain an objective of this program. The agency could explore supplemental funding from the local Agricultural community as well as the California Endowment.
ACCESS — EARLY INTERVENTION PROGRAMS

PROGRAM NAME: AFRICAN AMERICAN COMMUNITY PARTNERSHIP

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>PEI – Early Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>ACCESS Services</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Adult (26-59)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>African Americans and underserved racial/ethnic communities</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>The Village Project</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Seaside</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>85</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$5,611</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

The Village Project, Inc. was the product of many years of advocacy for fairness and equity in terms of African Americans and other underserved groups by behavioral health systems locally and beyond. In 2005, during a series of focus groups conducted throughout Monterey County for the initial 3-Year MHSA community program planning process, African American participants clearly stated they and other African Americans would come to therapy if there was a place where they felt comfortable that appreciated their culture, understood how best to work with them and demonstrated a strong appreciation of who they are as a people. As a result of these focus groups, in collaboration with MCBH, The Village Project, Inc. was founded and opened its doors in May 2008. The agency was created to provide therapeutic services for people of all age groups and a variety of diagnoses, primarily to African Americans. However, it has also provided services to Latinos, Asian/Pacific Islanders, children who are Bi-Racial and Tri-Racial, as well as Caucasian children and families.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of the African American Community Partnership is keep youth and adults from becoming involved in the juvenile justice and criminal justice systems, as well as prevent the need for emergency room/crisis unit visits and hospitalizations. The program provides tools to enable clients in taking charge of their lives, to prevent mental illness and other psychological/emotional issues from becoming severe and disabling. Progress towards achieving the above goals are assessed by using Avatar data, as well as a review of client charts towards progress goals and through client self-report. This program uses the Avatar electronic medical record system.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the African American Community Partnership served 85 clients. Of clients served, 29% were Latino and 2% were from South County. With racial equity figures below the goal of 75% Latino engagement and regional equity figures being well below the goal of 20% engagement of South County residents, the
African American Community Partnership, by definition, is contributing to other health equity goals in Monterey County.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 100% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA Plan period, seeking alternative and complimentary funding sources will remain an objective of this program. As this program demonstrated a limited contribution towards meeting our health equity goals in Monterey County, there is an expressed need to address these inequities as part of this program’s activities moving forward.
PROGRAM DESCRIPTION
The Community Partnership - LGBTQ Counseling program provides outreach, engagement and specialized outpatient mental health counseling (individual, family and group) for LGBTQ individuals and their significant others. In 2005, during a series of focus groups conducted throughout Monterey County for the initial 3-Year MHSA community program planning process, this population advocated for specific services to address the significant mental health challenges related to LGBTQ issues. Counseling services are provided in culturally and linguistically competent settings. Additionally, this program provides specialized trainings to staff, community providers and the therapist community on LGBTQ issues in relation to mental health. Public outreach at community-based events is also an element of this program.

PROGRAM GOALS AND EVALUATION METHODOLOGY
The program aims to improve mental and emotional health of individuals, and have a positive effect on health outcomes. Assessments of client outcomes utilizes a matrix evaluation tool specific to measuring mental health improvements in LGBTQ individuals. This program uses the Avatar electronic medical record system.

SERVICE DATA AND IMPACT ON HEALTH EQUITY
In FY16, the Community Partnership - LGBTQ Counseling program served 19 clients. Of clients served, 59% were Latino and none were from South County. When combined, these figures represent a limited contribution towards meeting our health equity goals in Monterey County, with racial equity figures being below the goal of 75% Latino engagement and regional equity figures being far below the goal of 20% engagement of South County residents. The reason for limited impact is due to small number (19) of clients served over the course of one year.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY
In FY16, MHSA funds accounted for 64% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA Plan period, seeking alternative and complimentary funding sources will remain an objective of this program. As this program demonstrated a limited contribution towards meeting the health equity goals of Monterey, there
is an expressed need to address these inequities as part of this program moving forward.
**PROGRAM NAME: 2-1-1 TELEPHONE REFERRAL SYSTEM**

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>PEI – Access and Linkage to Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>ACCESS Services</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>All Ages</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>All of Monterey County</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>United Way of Monterey County</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Accessed by county-wide by phone</td>
</tr>
<tr>
<td>Languages served:</td>
<td>Primarily English and Spanish, with accommodations available for the deaf and 170 other languages.</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>15,660</td>
</tr>
<tr>
<td>Cost Per Call in FY16:</td>
<td>$1.66</td>
</tr>
</tbody>
</table>

**PROGRAM DESCRIPTION**

2-1-1 Monterey County (MC) was launched February 2009 as a program of United Way Monterey County. 2-1-1 is a phone number but also a system for connecting people quickly and efficiently to social and health services they are seeking. The phone is the most common method of contact but resource information is also available via a website. The service is available 24/7 in 170 languages. There are a multitude of caller needs and 2-1-1 services attempt to provide resources to meet those needs based on what is available in the community. Callers reach a Call Specialist who has been highly trained, certified to assist, and be proactive in meeting their needs. Based on the nature of the conversation between caller and the Call Specialists, appropriate programs are brought to the attention of the caller. For example, the program has been pro-active in promoting certain programs such as CalFresh, Covered CA, and Bridging the Digital Divide among other initiatives. Additionally, 2-1-1 is used during times of natural or manmade disasters as a “go-to” number for anyone in the public to use to acquire the latest official information and as a feedback loop from the public to County officials.

**PROGRAM GOALS AND EVALUATION METHODOLOGY**

The program aims to provide high quality referrals to benefit callers and meet their needs. Outcomes measures to track the efficacy of this program include data on caller demographics and needs, referral services offered, and caller satisfaction. Data reports, included caller satisfaction survey responses, are provided to MCBH on a quarterly basis.

**SERVICE DATA AND IMPACT ON HEALTH EQUITY**

In FY16, the 2-1-1 served 15,660 callers. Of callers served, 55% of were Latino and 31% were Spanish speaking. Data is currently unavailable for South County, however 2-1-1 did establish a separate resource listing specifically for South County. As this service is accessed by phone and supports numerous languages, it is considered very helpful in meeting MCBH’s health equity goals.

**SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY**

In FY16, MHSA funds accounted for 64% of the total program budget. MCBH values the ability of programs
to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA Plan period, seeking alternative and complimentary funding sources will remain an objective of this program. As this program demonstrated a limited contribution towards meeting the health equity goals of Monterey, there is an expressed need to address these inequities as part of this program moving forward.
PROGRAM NAME: VETERAN'S REINTEGRATION TRANSITION PROGRAM

MHSA Component – Service Category: PEI – Access and Linkage to Treatment
MCBH Strategic Plan Service Area: ACCESS Services
MHSA Age Group: Adult (26-59)
Priority Population: Veteran’s
Service Provider: Monterey County Office of Military & Veterans Affairs
Service Location: Monterey and Salinas (willing to travel)
Languages served: English
Number of Clients Served in FY16: 693
Cost Per Client Served in FY16: $23

PROGRAM DESCRIPTION

Over 2 million U.S. military men and women who served in major combat operations are returning to private life. Many were exposed to combat stress and suffered injuries both visible and invisible. Their experiences produce emotional challenges, and for some, they exhibit long-lasting behaviors such as isolation, self-medication, alcohol, and other drug abuse, sometimes leading to criminal behavior. Best practices demonstrate that early mental health intervention and focused treatment can help these individuals and their families fully recover and lead quality and productive lives. Children are particularly impacted by the emotional challenges facing their families; therefore, early intervention and treatment can prevent permanent scars. Monterey County also has a large population of veterans and their dependents from the Vietnam Conflict who can also benefit from the services provided by the Veterans Reintegration Transition Program (VRTP). These veterans receive the support and services not provided to them when they were initially released from service. These veterans also assist the VRTP by serving as mentors for our returning service members, providing their experience and guidance. Vietnam veterans continue to make up much of homeless veterans in the community, followed by an increase of more recent conflict veterans, including female veterans. VRTP is committed to search out those who are in shelters, on the street, or in local correctional facilities to render assistance with mental health, healthcare and social service referrals.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The main goal of the VRTP is to provide education and awareness to veterans, their dependents and survivors on entitled benefits to include mental health services available in the community. Additionally, this program seeks to streamline the process of transitioning service members, veterans and their eligible dependents to healthcare, mental health services, education, employment and other community based services. Assisting those transitioning service members, veterans and their dependents who are eligible for Veterans Administration (VA) Healthcare to connect with the VA helps to preserve the local safety net funds for those unserved and underserved populations who are not eligible for VA benefits.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Veterans Reintegration Transition Program served 693 clients. Of clients served, 27% were Latino and none were from South County. When combined, these figures represent a lack of contribution
towards meeting our health equity goals in Monterey County, with racial equity figures being below the goal of 75% Latino engagement and regional equity figures being well below the goal of 20% engagement of South County residents.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 100% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA Plan period, seeking alternative and complimentary funding sources will remain an objective of this program. As this program demonstrated challenges in making contributions towards meeting the health equity goals of Monterey, there is an expressed need to address these inequities as part of this program.
COMMUNITY SERVICES AND SUPPORTS

CHILDREN’S SYSTEM OF CARE - FULL SERVICE PARTNERSHIPS

<table>
<thead>
<tr>
<th>PROGRAM NAME: FAMILY REUNIFICATION PARTNERSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHSA Component – Service Category</td>
</tr>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
</tr>
<tr>
<td>Priority Population:</td>
</tr>
<tr>
<td>Service Provider:</td>
</tr>
<tr>
<td>Service Location:</td>
</tr>
<tr>
<td>Languages served:</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

The Family Reunification Partnership (FRP) is a unique and innovative program model that truly integrates Children’s Behavioral Health (CBH) therapists and Family and Children’s Services (FCS/DSS) social workers into one cohesive program to help families in the reunification process. This program, conducted through MCBH, was developed out of the high need for support and services that many families required for successful reunification and follows the Department of Health Care Services Pathways to Mental Health Services Core Practice Model and the California Continuum of Care Reform approach. Additionally, the program design integrates critical mental health services into the coordinated approach to service delivery. This team approach is designed to improve coordination and collaboration among child welfare, mental health and other formal and informal supports, and more effectively serve those children and families involved with the child welfare system. Three FCS/DSS social workers work with three clinicians from CBH, paired in teams of two for each FRP family, they share a caseload and jointly provide an array of services to their families. They jointly share responsibility for case planning, provision of intensive therapeutic and support services, case monitoring, family team leadership, decision-making, and managing and leading orientation and other psycho-education groups.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of the Family Reunification Partnership program is to address the high intensity mental health needs of the children and families for improved individual and family functioning. Specific outcomes pursued to achieve this goal include decreased symptom acuity as measured by reduction in CANS needs scores, improved family functioning and relationships as measured by increased ratings in CANS family...
strengths items, and achievement of set treatment goals. Progress towards achieving the above goals are assessed by case coordinators, with CANS outcomes monitored using the Avatar electronic medical records system.

SERVICE DATA AND IMPACT ON HEALTH   EQUITY

In FY16, the Family Reunification Partnership served 45 clients. Of clients served, 64% of were Latino and 11% were from South County. Individuals served through this program are specific to children in foster care and involved in Juvenile Dependency court proceedings and therefore may not mirror the health equity goals for general mental health services delivery, i.e. 75% Latino and 20% South County residents.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 48% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. This program is jointly funded through DSS, allowing for shared fiscal investment in this innovative program which provides critical services to high needs families in our community.
PROGRAM NAME: TAY AVANZA

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>CSS – System Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>TAY</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>TAY (16-25)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Youth age 16-25 with Moderate to Severe Mental Health issues including co-occurring Substance Abuse disorders and their family members</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>MCBH</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Salinas</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>227</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$7,534</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

The TAY Avanza program provides mental health treatment and peer mentoring to youth and young adults ages 16 through 25 who have significant mental health disorders by providing comprehensive case management, therapy, groups and opportunities for positive social interactions. Avanza was originally developed by MCBH with a Federal System of Care Grant that allowed Monterey County to create developmentally appropriate mental health services for young adults. After the federal Grant ended, MCBH has sustained and grown the program with MHSA funds and Medi-Cal billing. In the 2014 MCBH Strategic Plan, the community provided feedback that they wanted continued and expanded supports for young adults with mental health disorders. Desired services included vocational training and assistance in gaining employment, as well as substance abuse treatment and family support. To address this community feedback, the TAY Avanza program provides linkages to community resources that assist youth in accessing vocational training, employment assistance as well as educational opportunities. The TAY Avanza program provides out-patient dual diagnosis treatment for youth with co-occurring substance abuse and mental health conditions and links youth with more severe co-occurring conditions to community resources that offer a higher level of care. Psycho-education and support is also provided to family members as they are an important part of a young adult’s support system and are critical in their success. To complement mental health services provided by staff, this program hired two (2) former clients as youth mentors to further engage young adults in the program and provide peer mentoring.

PROGRAM GOALS AND EVALUATION METHODOLOGY

In this program, goals are tailored to each youth, with a general focus on a stable, successful transition into adulthood. Individual goals can range from achieving educational or vocational pursuits, acquiring a stable living situation, and engaging with peer and social supports while also reducing symptoms of mental health challenges. Individual mental health outcomes and key events like finding employment and housing are assessed and tracked by a case manager, and monitored using the Avatar electronic mental health records system. A more robust evaluation component should be developed to report out on progress of clients in decreasing mental health symptoms and increasing functioning in key life domains of employment and/or
education, living stability/housing and social/community interactions. Psychometric measures are administered at the beginning of treatment for all clients and upon discharge, in addition to CANS/ANSA domains.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the TAY Avanza Full Service Partnership served 227 clients. Of clients served, 70% were Latino and 32% were from South County. When combined, these figures represent an excellent example of meeting our health equity goals in Monterey County, with racial equity figures approaching the goal of 75% Latino engagement and regional equity figures being above the goal of 20% engagement of South County residents.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 31% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. As this program demonstrated a positive contribution towards meeting the health equity goals of Monterey, there is an on-going awareness of the need to continue to address these inequities as part of this program moving forward.
PROGRAM DESCRIPTION

Integrated Co-Occurring Treatment (ICT) is a collaborative effort between Door to Hope, Monterey County Probation and Monterey County Behavioral Health (MCBH). ICT was implemented in 2008 and identified as the most effective approach to treating adolescents with co-occurring substance use and mental health disorders. Door to Hope began providing ICT to youth between the ages of 12-17 and in 2015, the program expanded to meet the needs of Transition Aged Youth ages 18-25. ICT is an intensive community-based program which provides an evidence based practice in a strength based, home visitation model. ICT services often begin with home, school and/or community visits by staff, and continue throughout the treatment process. MCBH provides psychiatric medication management in conjunction with ICT. Treatment is intensive and highly flexible, including evenings and weekends when required.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goals of ICT are to improve the overall functioning of youth and their family and reduce the need for residential care. Individual mental health and family functioning outcomes are monitored and assessed using the Ohio Rating Scale, which can be administered to a parent, teacher and/or service provider, as well as the Avatar Electronic Health Records system.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, ICT served 98 clients. Of clients served, 88% of were Latino and 22% were from South County. When combined, these figures represent a positive contribution towards meeting our health equity goals in Monterey County, with racial equity figures exceeding the goal of 75% Latino engagement and regional equity figures also exceeding the goal of 20% engagement of South County residents.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 50% of the total program budget. Specialty mental health services are
billed through Medi-Cal for all eligible clients. Within this 3-Year MHSA Plan period, evaluating the possibility of leveraging Drug Medi-Cal funding may be an alternative funding source for the ICT program. Throughout the years, ICT has provided services to include youth who are ordered into the Juvenile Drug Court Program. The Drug Court treatment program is generally provided through Monterey County Behavioral Health. A strategy for improving service delivery may include the centralization of services and clarifying clients best suited for ICT vs. Behavioral Health programs to avoid duplication of services and confusion among the providers and families being served.
PROGRAM NAME: JUVENILE MENTAL HEALTH COURT

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>CSS – FSP</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>Juvenile Justice</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Children &amp; Youth (0-15), TAY (16-25)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Youth ages 11 - 18 with a mental/co-occurring illness and substance abuse disorder other than a primary substance use disorder or developmental disorder, in detention at the Monterey County Juvenile Hall or have a filing of a delinquency petition.</td>
</tr>
</tbody>
</table>

Service Provider: MCBH
Service Location: Salinas
Languages served: English and Spanish
Number of Clients Served in FY16: 23 (19 Full Service Partnership/4 System Development)
Cost Per Client Served in FY16: $25,782

PROGRAM DESCRIPTION

The Collaborative Action Linking Adolescents (CALA) program is a comprehensive Full Service Partnership (FSP) juvenile mental health court project that was developed by Monterey County Probation, District Attorney, Public Defender, Behavioral Health, and the Superior Court of California. The program began in FY08 with grant funds from the State Mentally Ill Offender Crime Reduction project. When the grant funds expired, the county collaborative has continued to combine resources to maintain the operation of the CALA program. The CALA program provides intensive mental health services and case management to youth and their families, in collaboration with a Probation Officer (PO) supervising these youths.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The primary goal of the CALA program is to reduce incarcerations of youth with mental illness and/or co-occurring disorders. Ancillary goals of CALA FSP activities are to improve individual and family functioning, reduce risk behaviors associated with violence and substance abuse, improve emotional well-being and resilience/coping skills and less youth being removed from their home or community. Outcomes pursued by CALA supportive services are monitored by a case manager and the Avatar electronic medical records system. Clients are screened with the Massachusetts Youth Screening Instrument Version 2 (MAYSI-2).

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, CALA served 23 clients. Of clients served, 68% of were Latino and 5% were from South County. The CALA program treats clients engaged with the juvenile justice system, therefore demographics of clients are established by circumstances outside the influence of CALA program activities and demographic data does not directly pertain to MCBH health equity goals. However, this demographic data may be used for planning purposes of future Prevention programs.
SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 65% of the total program budget. MHSA funds are an appropriate source of funding for services provided by CALA, as this program is in direct alignment with the MCBH Strategic Plan and serves the safety net population.
PROGRAM NAME: INCARCERATION TO SUCCESS

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>CSS – FSP</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>Juvenile Justice</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>TAY (ages 16-25)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Males ages 16-22 on probation or part of the Juvenile Justice System through MCBH</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>Peacock Acres, Inc.</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Salinas</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>7</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$54,687</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

The Incarceration to Success (I2S) Program is a collaborative partnership between MCBH, Monterey County Probation Department and Peacock Acres. I2S provides transitional housing for male Transition Age Youth who are exiting the Monterey County Youth Center as well as other youth involved with Juvenile Probation and MCBH who are unable to return home, for various circumstances, and are in need of stable housing with independent living coaching. In I2S, youth are taught independent living skills, job skills and case management services that are able to support their mental health needs and increase their ability to live independently while reducing the risk of recidivism and increase mental health stability. I2S also guides youth by using intensive case management services, groups, and working as part of the therapeutic treatment team and collaboration with county agencies to assist these young adults in their transition into adulthood. By doing this, they are allowing the youth to engage in healthy community activities, teaching them how to build healthy relationships to allow youth to practice their learned prosocial skills in the community. Through this Full-Service Partnership, no party is unilaterally making decisions for eligibility into the program. I2S, Probation and Behavioral Health meet bi-monthly to discuss current residents, address concerns, and develop a plan of action to assist the youth in becoming a productive, positive member of the community. In addition to the bi-monthly meetings, all partners meet with the treatment team and the youth and their family as deemed most appropriate in meeting the youth’s needs.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of this program is successful transition by youth into independent living, free of criminal offenses with increased mental health stability and improved overall functioning in the community. Individual mental health outcomes and key events like finding employment, housing, and re-offenses are assessed and tracked by a case manager, therapist and probation officer (as deemed appropriate), the CANS (Child and Adolescent Needs and Strengths) tool, and monitored using the Avatar electronic medical records system.
SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Incarceration to Success (I2S) program served 7 clients. Of clients served, 86% were Latino and none were from South County. Although the racial equity figure exceeded the goal of 75% Latino engagement, the regional equity figure is well below the goal of 20% engagement of South County residents.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 70% of the total program budget. Specialty mental health services are billed through Medi-Cal for all eligible clients. This program fits within the MCBH Strategic Plan initiatives, as it focuses on providing services to both Transition Age Youth as well as Youth involved in the Juvenile Justice System. Within this 3-Year MHSA Plan period, strategies for growth and improved service delivery include ongoing collaboration between and within the partnering agencies to address youth and program needs, progress, goals, and plans of action for successful independent community living. Examples may include, increased partnership participation in the youth’s Life Conference as well as developing a discharge plan upon entry into the program. A more cohesive partnership that addresses timelines and expectations would assist the youth in having a clear understanding of reasonable expectations and program guidelines.
CHILDREN’S SYSTEM OF CARE – GENERAL SYSTEM DEVELOPMENT

PROGRAM NAME: ADOPTION PRESERVATION

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>CSS – System Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>Adoption Preservation</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Children &amp; Youth (0-15)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Any pre- and post-adoption family that is caring for children aged 0-17 in Monterey County.</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>Kinship Center / Seneca</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Salinas</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>3</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$17,645</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

The Adoption Preservation program was formed to address the on-going needs of post-adoptive families. Research has shown that adoption disruptions can be prevented through the utilization of a continuum of adoption related services that include case management, therapeutic care, and skills acquisition training. In this program, children and youth who are at acute risk for disruption in home or school placement, or loss of community access to extra-curricular activities, will receive a team based, coordinated approach that will include a Child & Family Therapist and Family Support Counselor, and access to psychiatric, psychological assessment and occupational therapy services as needed. Parents are referred and encouraged to participate in parent education programs aimed at enhancing the impact of mental health intervention. To ensure that services are known in underserved regions of Monterey County, program representatives routinely participate in local resource events that are held in predominately Spanish Speaking agricultural communities. They also engage in targeted outreach in schools, libraries, WIC offices, and YMCA’s in underrepresented areas throughout the county.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of the Adoption Preservation Program is to strengthen families and increase their level of attachment, efficacy, feelings of safety and psychological well-being to increase the permanency of adoption placements and thereby reduce the substantial costs associated with caring for children in the foster care system. By stabilizing these family placements, the program also intends to help reduce the negative outcomes associated with children who grow up predominately in foster care, including: poverty, teen pregnancy, juvenile delinquency, and lack of educational attainment. The mental health treatment component addresses the underlying issues such as loss, abuse, trauma, disrupted attachment, mood dysregulation, and social skills deficits that foster children are often impacted by. These mental health issues, when untreated, frequently lead to disrupted adoptions as a result of the significant stresses on the family. Goals of this program include: reduction in symptoms, improved client and family functioning, increased positive social engagement, and improved educational achievement. Progress towards achieving
the above goals are assessed by case managers, through treatment and outcome assessment tools such as the Child Behavior Checklist, Youth Self Report, Parental Stress Index, and the CANS and then are monitored and recorded using the Avatar electronic medical records system.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Adoption Preservation program served 3 clients. Of clients served, 100% were Latino and 33% were from South County. When combined, these figures represent a strong contribution towards meeting our health equity goals in Monterey County, with racial equity figures exceeding the goal of 75% Latino engagement and regional equity figures exceeding the goal of 20% engagement of South County residents.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 9% of total program budget. Within this 3-Year MHSA Plan period, the program will address capacity to provide more timely response to County requests for reporting of service data, outcome data, and other reporting and invoicing as required by the County.
PROGRAM NAME: SECURE FAMILIES/ FAMILIAS SEGURAS

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>CSS – System Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>At Risk of Placement</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Children &amp; Youth (0-15)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Children 0-5 and their parent / caregivers.</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>MCBH</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Castroville, Seaside, Salinas and King City</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>151</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$3,818</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

MCBH has partnered with the community and First 5 to provide specialized mental health services for young children age 0-5 and their families over the past 10 years. In large part due to First 5 community education efforts and an increased awareness in the mental health profession, MCBH has sustained and grown our service array to meet the needs of young children and their families. In the past, our collaborative program was called “School Readiness” and has evolved into our Secure Families/Familias Seguras Program.

The Secure Families/Familias Seguras program has, as its core value, the provision of culturally and linguistically appropriate behavioral health services for children ages 0-5 and their caregivers/family members that supports both the positive emotional and cognitive development in children and increases caregiver capacity to address their children’s social/emotional needs. Clients served in the program come from vulnerable families who have experienced trauma, poverty and disenfranchisement. Services include Dyadic Therapy (parent/caregiver and child), Parent-Child Interaction Therapy, Circle of Security Groups, Child Parent Psychotherapy (CPP), Developmental and Social-Emotional Screenings and case management to link families with community based resources to support optimal child development and family functioning.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of this program is to decrease mental health symptoms, increase ability of children to regulate emotions, increase parental understanding of their children’s needs, and parental ability to respond to those needs. Progress towards achieving the above goals are assessed by using clinician observation and caregiver/family member report. This program uses Avatar for electronic health record monitoring. The program is currently evaluating Family Outcome measures that would better track client and family member progress in treatment.
SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Secure Families program served 151 clients. Of clients served, 80% were Latino and 30% were from South County. When combined, these figures represent a strong contribution towards meeting our health equity goals in Monterey County, with racial equity figures being above the goal of 75% Latino engagement and regional equity figures meeting the goal of 20% engagement of South County residents.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 48% of total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA Plan period, seeking alternative and complimentary funding sources will remain an objective of this program. As this program demonstrated a positive contribution towards meeting the health equity goals of Monterey, there is an ongoing awareness of the need to continue to address these inequities as part of this program.
PROGRAM NAME: FAMILY PRESERVATION

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>CSS – System Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>At Risk of Placement</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Children &amp; Youth (0-15)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Any minor child that is at risk for placement in publicly funded care and is from a monolingual Spanish speaking family is eligible for this program.</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>MCBH</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Salinas (with the ability to meet at clients’ homes)</td>
</tr>
<tr>
<td>Languages served:</td>
<td>Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>1</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$115,057</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

The Family Preservation program is an intensive, short-term, in-home crisis intervention and family education program for monolingual Spanish-speaking families in Monterey County. The program is designed to prevent out-of-home placement of children whose emotional, social, and/or behavioral problems create a substantial risk of placement in publicly-funded care, such as foster homes, group homes, correctional institutions, or psychiatric facilities. This program is designed to defuse the immediate crisis, stabilize the environment, and assist families in developing more effective parenting skills and coping abilities. Through in-home mental health intervention and psycho-education, this program enables parents to meet the high needs of their children, build safer and more secure relationships within their family, and create a long term support system. This program encourages families to remain together, even in high intensity situations, as the focus is on educating and empowering families to meet the needs of their children.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of the Family Preservation program is to prevent out-of-home placement. Specific outcomes pursued to achieve this goal include improved family functioning and relationships, along with improved mental health and well being at the individual level. Progress towards achieving the above goals are assessed by case managers, with health activities and outcomes monitored using the Avatar electronic medical records system.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Family Preservation program served 1 Latino child and his/her family from South County. The impact of service delivery is inadequate, however, the program design and specific services provided are identical to the Home Partners program provided through MCBH and the population being served is the same.
SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 36% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA plan period, it is recommended that this program be combined with the Home Partners program (see below), allowing for greater service delivery to both the Latino and South County populations of Monterey County. Home Partners program have bi-lingual Spanish/English service delivery capacity and with the additional funding from this program could increase program capacity by an additional 60%.
**PROGRAM NAME: HOME PARTNERS**

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>CSS – System Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>At Risk of Placement</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Children &amp; Youth (0-15)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Families where there is imminent risk of the child being placed in out of home care are the focus of this program.</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>MCBH</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Based in Salinas with the ability to meet at clients' homes</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>16</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$8,629</td>
</tr>
</tbody>
</table>

**PROGRAM DESCRIPTION**

The Home Partners Program is an intensive, short-term, in-home crisis intervention and family education program. The program is designed to prevent out-of-home placement of children whose emotional, social, and/or behavioral problems create a substantial risk of placement in publicly funded care, such as foster homes, group homes, correctional institutions, or psychiatric facilities. The Home Partners program is designed to defuse the immediate crisis, stabilize the environment, and assist families to develop more effective parenting skills and coping abilities. The principal characteristics of this program include interventions at the crisis point, treatment in the client’s environment, 24/7 therapist availability and highly individualized treatment. Services are provided intensively and as needed, typically over a four to six (4-6) week period. These services support parents/caregivers to meet the high mental health needs of their children; strengthening safe relationships within their family leading to a long-term support system.

**PROGRAM GOALS AND EVALUATION METHODOLOGY**

The goal of Home Partners program is to sufficiently address imminent mental health needs to improve child functioning and prevent out-of-home placement. Specific outcomes pursued to achieve this goal include decreased symptom acuity as measured by reduction in CANS scores, improved family functioning and relationships as measured by increased ratings in family strengths in the CANS, and achievement of individualized treatment goals. Progress towards achieving the above goals are assessed by assigned clinicians, with CANS outcomes monitored using the Avatar electronic medical records system.

**SERVICE DATA AND IMPACT ON HEALTH EQUITY**

In FY16, the Home Partners program served 16 clients; 56% of were Latino and 13% were from South County. However, clients referred to the program are those Monterey County residents that are at highest risk for removal from their home environments and therefore the demographics of clients requiring this intensive service may not mirror overall health equity goals.
SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 48% of the total program budget. The program also leverages Medi-Cal billing for eligible clients. Within this 3 year MHSA Plan period, the program will address the service delivery system to enable an increased number of families that can be served by the program by 40%. Additionally, it is recommended that this program be combined with the Family Preservation program (see above).
PROGRAM NAME: SANTA LUCIA RESIDENTIAL PROGRAM FOR ADOLESCENT FEMALES

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>CSS – System Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>Juvenile Justice</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Children &amp; Youth (0-15)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Adolescent females age 13-18 who are wards of the court and require residential care with a significant substance use and co-occurring mental health disorder</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>Door to Hope</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Salinas</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>16</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$32,730</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

The focus of the Santa Lucia Residential Program is to identify, assess, and treat adolescent females who exhibit significant levels of psychiatric, emotional/behavioral, co-occurring mental health and substance abuse needs and are unable to maintain in any other type of living situation. In this program, Door to Hope provides intensive mental health services, in conjunction with MCBH’s psychiatric medication management as deemed clinically appropriate, to eligible adolescent females and their families. Individual, family, or group therapies and interventions designed to reduce mental health disabilities, and improve and maintain functioning consistent with the goals of learning, development, independent living and enhance self-sufficiency and family functioning are provided. The Santa Lucia Residential Program is the only female, adolescent residential facility in Monterey County and without their services, there would be a significant void; these youth would be placed out of county, increasing barriers to family services. Treatment addresses such critical needs as serious emotional disturbance, behavioral dyscontrol, sexual exploitation, multiple foster care and/or residential placements, gang issues, community violence, substance abuse, complex and acute traumas, and populations whose cultural differences have historically excluded them from traditional mental health services. Door to Hope meets with MCBH in monthly collaborative meetings to address psychiatric care, clinical concerns and progress. Through this collaborative effort, we can ensure the mental health, family and substance use needs are being met and assist the youth in returning home with their families or to a transitional housing program where they are able to implement their learned prosocial and adaptive skills and increase the likelihood of becoming a productive member of the community, reduce the risk of recidivism and reduce additional, long term involvement with the Justice System.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of this program is to provide mental health and substance use disorder services while decreasing the risk of long term involvement with the juvenile justice system and out-of-home placements. Outcomes pursued by this program include a youth’s improved overall functioning, a reduction in acute behavioral
symptoms, improvement in family well-being and functioning, and reduced involvement in the juvenile justice system while returning the youth to their family or long term independent living in the community. Individual mental health and family functioning outcomes are monitored and assessed using the Ohio Rating Scale, which can be administered to a parent, teacher and/or service provider, as well as the Avatar electronic medical records system.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Santa Lucia Residential Program For Adolescent Females served 16 clients. Of clients served, 81% were Latino and 6% were from South County. When combined, these figures represent a positive contribution towards meeting our health equity goals in Monterey County, with racial equity figures exceeding the goal of 75% Latino engagement, however, the regional equity figure is well below the goal of 20% engagement of South County residents.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 49% of the total program budget. Specialty mental health services are billed through Medi-Cal for all eligible clients. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. It should be noted that youth for this program are selected by need and placement fit. Within this 3-Year MHSA Plan period, under the new CCR (Continuum Care Reform) legislation, Santa Lucia Residential Program will need to pursue certification and licensure as a Short Term Residential Therapeutic Program (STRTP), which will require some program changes and service delivery development. Additionally, services will shift to meet the highest level of clinical needs, to the most severe population.
PROGRAM NAME: NUEVA ESPERANZA

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>CSS – System Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>At Risk of Placement</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Children &amp; Youth (0-15), Adult (18+)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Women over the age of 18, with a significant substance abuse disorder and co-occurring mental health disorder, who are pregnant or have custody of a child under the age of 5.</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>Door to Hope</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Salinas</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>47</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$12,807</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

Nueva Esperanza is a program operated by Door to Hope that serves pregnant or parenting women over the age of 18 who are experiencing problems with alcohol and/or other drugs of sufficient severity necessitating the need for residential care for themselves and their young children. In July of 2011, Nueva Esperanza modified its primary mission and service delivery system to provide an expanded constellation of mental health services to better meet the needs of the women and the children it serves. Historically, all of the women admitted to Nueva Esperanza have co-occurring mental health disorders (such as bi-polar, mood, and trauma disorders). Door to Hope and Nueva Esperanza meet the needs of this population through the provision of integrated mental health and substance abuse disorder treatment. These services are provided in a warm and comfortable drug-free, non-smoking environment. The facility provides private rooms for each individual family to promote cohesion and autonomy. Each resident is viewed as a unique individual and each family is seen from a strength-based approach. Due to the comprehensive nature of behavioral health disorders, Nueva Esperanza makes available a complete range of medical, psychological, recovery, dyadic, parenting, and other social services on either a programmatic, consultative, or referral basis.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of this program is to increase each woman’s readiness and ability to change, to treat chronic mental health and substance abuse disorders, and educate these pregnant women and mothers of young children on the effects of alcohol, drug, and/or trauma exposure on the unborn or young. Individual mental health and family functioning outcomes are assessed by a case manager and monitored using the Avatar electronic mental health records system. During this 3 year MHSA Plan period, specific outcome assessment measures should be identified to evaluate the impact of services on the identified program goals.
SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Nueva Esperanza program served 47 clients. Of clients served, 64% of were Latino and 4% were from South County. The racial equity figures represent a modest contribution towards meeting our health equity goals in Monterey County by achieving close to the goal of 75% Latino engagement, while regional equity figures are well below the goal of 20% engagement of South County residents.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 18% of total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources and the program has demonstrated the ability to provide mental health services that were billed to Medi-Cal, however an internal Quality Assurance audit found potential audit exceptions. Moving forward, this program must consistently demonstrate the capacity to provide adequate documentation in compliance with Medi-Cal billing requirements for specialty mental health services. Within this 3-Year MHSA Plan period, seeking alternative and/or complimentary funding sources will remain an objective of this program and the Drug Medi-Cal service delivery system as a funding option should be explored.
ADULT SYSTEM OF CARE - FULL SERVICE PARTNERSHIPS

PROGRAM NAME: INTEGRATED CARE/ OLDER ADULT FSP

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>CSS - FSP</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>Adult Services</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Older Adult (60+)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Older Adults with SMI</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>MCBH</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Marina</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>16</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$8,247</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

The Integrated Care/Older Adult Full Service Partnership (FSP) provides intensive and frequent services for older adults with serious mental illnesses and complex medical issues who are at risk of losing their community placement, hospitalization, institutionalization, and homelessness. The FSP provides wrap-around services which enables the case coordinator to have a smaller caseload to provide mental health services and case management with the assistance of a dedicated team. By establishing the FSP, this has improved the quality of life for older adults by preventing out of county and locked placements which is a high cost to the County. These intensive services have also helped reduce unplanned emergency services and admissions to inpatient psychiatric hospitals, which enhances the quality of life for older adults.

PROGRAM GOALS AND EVALUATION METHODOLOGY

This specialty program has a goal of reducing psychiatric hospitalizations and maintaining the client in their living environment. This allows the client to live in the least restrictive level of care and enhances their quality of life. The anticipated outcome is to assist clients with obtaining psychiatric stability as evidenced by a reduction of psychiatric hospitalizations or use of mental health crisis resources.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Integrated Care/Older Adult FSP served 16 clients. Of clients served, 94% of were White and 6% were from South County. These figures represent the need for a systematic review of the referral mechanisms used to enroll clients in this Program, as the client demographic data indicates the program is falling short of meeting both our health equity goals in Monterey County, i.e. 75% Latino engagement and 20% engagement of South County residents.
SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 100% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA Plan period, seeking alternative and complimentary funding sources will remain an objective of this program. As this program demonstrated challenges in meeting the health equity goals of Monterey County, there is an expressed need to address these inequities as part of this program.
PROGRAM NAME: MENTAL HEALTH COURT - CREATING NEW CHOICES

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>CSS – FSP</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>Adult Services</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>TAY (18-25) Adult (26-59) Older Adult (60+)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Adults with serious mental illness (schizophrenia, schizoaffective disorder or bi-polar disorder) who have an arrest or a violation of probation on an existing probation grant. Misdemeanor or non-serious, non-violent felony charges only.</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>MCBH</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Salinas</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>34</td>
</tr>
<tr>
<td>Average Service value per Client Served:</td>
<td>$18,146</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

Creating New Choices (CNC) was originally launched with funds from the Mentally Ill Offender Criminal Reduction Grant and then enhanced with MHSA funding. These funds allowed for development of Mental Health Treatment Court to serve the mental health needs of adults with severe mental illness who encounter the criminal justice system. CNC is a collaborative effort between the Superior Court, MCBH, Probation Department, District Attorney’s Office, Public Defender’s Office and the Sheriff’s Office and is aimed at reducing the repetitive cycle of arrest and incarceration for defendants who have serious mental disorders by providing intensive case management, psychiatric care, probation supervision and therapeutic mental health court services. A full-time Probation Officer is co-located with MCBH staff and coordinates client supervision and treatment activities through regular contact and case coordination activities with the designated CNC Supervisor and other clinical/case management MCBH staff. As a Full Service Partnership (FSP), the CNC team provides participants with a wide range of services including: individual and group therapy, medication management by a psychiatrist, individualized treatment planning, housing resources, life skills, transportation support, school and/or employment assistance, and 24/7 access to CNC team member for crisis intervention and support. Adult Mental Health Treatment Court hearings with a Therapeutic Court Team, comprised of a Judge, District Attorney and Public Defender along with Probation and CNC staff, are an integral part of the treatment program. CNC clients have regular court hearings to review their progress in treatment including program participation, recovery work, personal accountability and pro-social behavior.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of CNC is to reduce recidivism and to stabilize the individual in the community by increasing client compliance with Probation supervision and mental health treatment, including medication compliance, as ordered by the Mental Health Treatment Court. Individual mental health outcomes and key events like re-offenses are assessed and tracked by the case manager, and monitored using the Avatar electronic mental
health records system. A successful outcome is a client who completes the CNC program by graduating from Mental Health Treatment Court after meeting all the terms and conditions of Probation; has learned coping skills to better manage and understand the symptoms of their mental illness and has stabilized in the community without reoffending or re-incarceration. This client is then transitioned to another team within the Adult System of Care to receive ongoing mental health services.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Creating New Choices program served 34 clients. Of clients served, 35% were Latino and 3% were from South County. These figures represent the need for a systematic review of the referral mechanisms used to enroll clients in this Program, as the client demographic data indicates the program is falling short of meeting both our health equity goals in Monterey County, i.e. 75% Latino engagement and 20% engagement of South County residents.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16 MHSA funds accounted for 66% of the total program budget. Monterey County Behavioral Health values the ability of programs to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA Plan period, seeking alternative and complimentary funding sources will remain an objective of this program. As this program demonstrated a minimal contribution towards meeting the health equity goals of Monterey County, there is a need to address these inequities as part of this program. A challenge in doing this is the manner in which clients are referred to Mental Health Treatment Court. All involved justice partners (the Judge, District Attorney, Public Defender, Probation and Behavioral Health) must agree on an individual’s eligibility for acceptance into the program. To increase the number of referrals to this program, the Behavioral Health Services Manager conducts several presentations to law enforcement agencies throughout the county as well as has presented to the public defender’s office to increase knowledge and awareness of the existing Therapeutic Justice Courts including Adult Mental Health Treatment Court. MCBH looks forward to collaborating with the Probation Department to address these concerns over this program’s minimal contribution towards meeting the county’s health equity goals and the low penetration rate specifically in the South County region. Additional areas for improvement are a) enroll other clients that have current/recent Forensic involvement, as this team is uniquely qualified to work with clients that have experience with the Criminal Justice system; and b) provide the appropriate level of intensity needed by each client referred to this program, to stabilize their mental health challenges and support them in their recovery journey.
PROGRAM NAME: MCHOME

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>CSS - FSP</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>Residential Placement / Supported Housing</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Adult (26-59)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Adults with serious mental illness and/or functioning limitations that substantially interfere with ability to carry out primary aspects of daily living in the community</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>Interim Inc.</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Marina, CA with countywide outreach Soledad House, Salinas, CA Wesley Oaks, Salinas, CA</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>73</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$12,375</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

The MCHOME Program is a Full-Service Partnership (FSP) initiative. The purpose of the program is to assist adults with mental illness, including those served by the Adult System of Care, and Access, to move off the street into housing and employment and/or on benefits through outreach, assessments, intensive case management services, mental health services, and assistance with daily living skills.

Soledad House serves as transitional housing for MCHOME clients to reside in for no more than one year. This housing operates on the “housing first" model, and may also be used for temporary housing for persons not yet enrolled in the FSP. Soledad House provides a central place and a program identity that fosters positive peer support, and provides consumers with the tools to maintain their housing. Wesley Oaks is an intensive permanent supportive housing program, which provides a FSP level of services to four (4) very low-income individuals with a serious mental health diagnosis, all of whom are homeless or at high risk of homelessness.

The service array of MCHOME includes intensive case management and mental health services provided in the FSP model, and independent living skills development in order to help residents live self-sufficiently in the community. MCHOME combines these intensive mental health services with shelter/housing support to vulnerable individuals with a psychiatric disability who are homeless or at-risk of homelessness. The program also focuses on helping individuals who are not currently receiving services from the public behavioral healthcare system to obtain psychiatric medications and other needed medical services. The program also works closely with the Department of Social Services to help individuals to enroll in benefits, including Social Security or SSI. Interventions are designed to minimize mental disability and maximize the restoration or maintenance of functioning consistent with the requirements for learning, development, independent living, and enhancing self-sufficiency.
PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of the MCHOME program is to prevent further homelessness, to avoid costly hospitalization or use of short-term crisis residential programs, hospital crisis teams, and unnecessary institutionalization in residential care homes. Client level outcomes, using Key Event Tracking documentation as well as the “Illness Management and Recovery Outcome Survey”, are measured and documented in the Avatar electronic medical records system.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the McHome program served 73 clients. Of clients served, 22% were Latino and 3% were from South County. When combined, these figures represent a lack of contribution towards meeting our health equity goals in Monterey County, with racial equity figures being well below the goal of 75% Latino engagement and regional equity figures being well below the goal of 20% engagement of South County residents.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 60% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA Plan period, seeking alternative and complimentary funding sources will remain an objective of this program. As this program demonstrated challenges in meeting the health equity goals of Monterey County, there is an expressed need to address these inequities as part of this program moving forward. Additional areas for improvement include monitoring the following: a) Clients served who had previously been open to ASOC; b) Clients served by MCHOME who are referred to ACCESS or ASOC; c) Clients who are discharged to lower levels of care through the use of the Recovery Needs Level; and d) Clients’ progress in their recovery through the use of the Recovery Markers Instrument and the Consumer Recovery Marker.
PROGRAM DESCRIPTION

Lupine Gardens is an intensive permanent supportive housing program, which provides a Full Service Partnership (FSP) level of services to 20 very low-income individuals with a serious mental health diagnosis, all of whom are homeless or at high risk of homelessness. The service array includes: intensive case management provided in the FSP model as required by the MHSAct, and assistance with daily living skills i.e., meals, house cleaning, self-administration of medication, and laundry services in order to live independently in the community. Lupine Gardens provides intensive mental health services and permanent supportive housing to vulnerable individuals with a psychiatric disability who are homeless or at-risk of homelessness. The goal is to prevent further homelessness, to avoid costly hospitalization or use of short-term crisis residential programs, hospital crisis teams, and unnecessary institutionalization. The program is designed for individuals who have failed in other placements and who need a high level of support to live in permanent housing. Mental health services are interventions designed to minimize mental disability and maximize the restoration or maintenance of functioning consistent with the requirements for learning, development, independent living, and enhancing self-sufficiency.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of this program is to provide permanent housing for a vulnerable group of individuals. The program also provides intensive case management and case coordination services in which the client and case manager work together to develop and begin taking steps to achieve the consumers recovery goals. Client level outcomes, using Key Event Tracking documentation as well as the “Illness Management and Recovery Outcome Survey”, are measured and documented in the Avatar electronic medical records system.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Lupine Gardens program served 22 clients. Of clients served, 18% of were Latino and none were from South County. When combined, these figures represent lack of contribution towards meeting our health equity goals in Monterey County, with racial equity figures being well below the goal of 75% Latino engagement and regional equity figures being well below the goal of 20% engagement of South County residents.
SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 50% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA Plan period, seeking alternative and complimentary funding sources will remain an objective of this program. As this program demonstrated challenges in meeting the health equity goals of Monterey County, there is a need to address these inequities as part of this program. Additional areas for improvement include monitoring the following: a) the number of discharges to lower levels of care via the Recovery Needs Level; b) the recovery of each consumer through the Recovery Marker Inventory and the Consumer Recovery Markers; and c) the number of discharges from Lupine Gardens to a lower level of care over the course of the year.
PROGRAM NAME: SUNFLOWER GARDENS

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>CSS – FSP</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>Residential Placement / Supported Housing</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Adult (26-59)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Adults with serious mental illness</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>Interim Inc.</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Salinas</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>31</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$8,175</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

Sunflower Gardens is an intensive permanent and transitional supportive housing program, which provides a Full Service Partnership (FSP) level of services to 23 very low-income individuals with a serious mental health diagnosis, all of whom are homeless or at high risk of homelessness. The service array includes assessments, evaluation, case coordination, intensive case management provided in the FSP model, assistance in accessing benefits, and assistance with daily living skills in order to help consumers meet the terms of their lease, and live independently in the community. Sunflower Gardens provides case coordination, intensive mental health services and permanent or transitional supportive housing to vulnerable individuals with a serious mental illness who are homeless or at-risk of homelessness.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of this program is to prevent further homelessness, to avoid costly hospitalization or use of short-term crisis residential programs, hospital crisis teams, and unnecessary institutionalization in residential care homes, and instead to increase resilience and self-sufficiency. Interventions are designed to minimize functional impairment due to serious mental illness and maximize the restoration or maintenance of functioning consistent with the requirements for learning, development, independent living, and enhancing self-sufficiency. Client level outcomes, using Key Event Tracking documentation as well as the “Illness Management and Recovery Outcome Survey”, are measured and documented in the Avatar electronic medical records system.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Sunflower Gardens program served 31 clients. Of clients served, 32% of were Latino and none were from South County. When combined, these figures represent lack of contribution towards meeting our health equity goals in Monterey County, with racial equity figures being well below the goal of 75% Latino engagement and regional equity figures being well below the goal of 20% engagement of South County residents.
In FY16, MHSA funds accounted for 50% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA Plan period, seeking alternative and complimentary funding sources will remain an objective of this program. As this program demonstrated challenges in meeting the health equity goals of Monterey County, there is an expressed need to address these inequities as part of this program moving forward. Additional areas for improvement include the following: a) Assess for current level of need by performing the Recovery Needs Level Instrument, b) Discharge to lower levels of clinical service measured by the Recovery Needs Level Instrument; and c) Measure quarterly progress in Recovery by the Recovery Markers Inventory and the Consumer Recovery Markers.
**PROGRAM NAME: DRAKE HOUSE**

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>CSS - FSP</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>Residential Placement / Supported Housing</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Older Adult (60+)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Adults age 60 and above with a serious mental illness and co-occurring physical illness(es)</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>Front St., Inc.</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Monterey</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>25</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$52,555</td>
</tr>
</tbody>
</table>

**PROGRAM DESCRIPTION**

Drake House is a 49-bed residential care facility which was initially implemented through a collaborative effort between Front Street Inc., Monterey County Behavioral Health. This facility was developed in response to a community need to maintain clients in their local environment and therefore, avoid high cost out-of-county placements. Drake House serves between 20 and 25 Monterey County residents who have co-occurring mental health and physical conditions that have been either unserved or underserved in Monterey County. It is a unique facility that has trained mental health clinicians on site in addition to part time nursing and psychiatry serving this over 60 age group. The program assists residents with medication, medical appointments, daily living skills, money management, and structured activities. The program assists clients in decreasing symptoms or behaviors that can result in the utilization of higher levels of care by providing the maximum level of supervision. The array of mental health services provided include: assessment, evaluation, mental health services, plan development, case management, and collateral (family member and other significant others) contacts.

**PROGRAM GOALS AND EVALUATION METHODOLOGY**

In providing all-inclusive wrap around services in their home community, the Drake House program provides an opportunity for intensive psychiatric and nursing services with the goal of reducing the utilization of ongoing unplanned emergency services to emergency departments, hospitals, mental health units, jails and other high cost facilities. The facility also provides a level of supervision and intensive interaction that is consistent with the clients’ needs as outlined in their individualized care plan. The program has also implemented a Wellness/Recovery program to reduce the incidence of co-morbid diseases, such as obesity, diabetes, high blood pressure and substance misuse. Health education and exercise programs are integrated into the overall treatment program.

The goal of this program is to reduce psychiatric hospitalizations and maintain the client at the Drake House program which enhances their quality of life, increases socialization, and allows the clients to live in the least restrictive level of care.
SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Drake House program served 25 clients. Of clients served, 4% were Latino and 4% were from South County. When combined, these figures represent a lack of contribution towards meeting our health equity goals in Monterey County, with racial equity figures being well below the goal of 75% Latino engagement and regional equity figures being well below the goal of 20% engagement of South County residents.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 70% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA Plan period, seeking alternative and complimentary funding sources will remain an objective of this program. As this program demonstrated challenges in meeting the health equity goals of Monterey County, there is an expressed need to address these inequities as part of this program moving forward.
ADULT SYSTEM OF CARE – GENERAL SYSTEM DEVELOPMENT

PROGRAM NAME: ROCKROSE GARDENS

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>CSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>Residential Placement / Supported Housing</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Adult (26-59)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Adults with serious mental illness</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>Interim Inc.</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Marina</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>21</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$5,481</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

Rockrose Gardens is a permanent supportive housing program providing housing to 20 very low-income individuals with serious mental illness; nine (9) of these individuals are homeless or at-risk of homelessness. Interim, Inc. provides case management, crisis intervention, and mental health services for residents in accordance with state guidelines established under the rehabilitation option, and in accordance with MHSA funding regulations. Interventions are designed to minimize disability and maximize the restoration or maintenance of functioning consistent with the requirements for learning, development, independent living, and enhancing self-sufficiency.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of this program is to assist low income and homeless individuals with serious psychiatric disabilities to maintain safe, affordable, supportive permanent housing. This prevents people from homelessness or institutional placement. Client level outcomes are monitored using the “Illness Management and Recovery Outcome Survey”, which are documented in the Avatar electronic medical records system.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Rockrose Gardens program served 21 clients. Of clients served, 14% of were Latino and none were from South County. When combined, these figures represent lack of contribution towards meeting our health equity goals in Monterey County, with racial equity figures being well below the goal of 75% Latino engagement and regional equity figures being well below the goal of 20% engagement of South County residents.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 50% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA Plan period, seeking alternative and complimentary funding sources will remain an objective of this program. As this
program demonstrated challenges in meeting the health equity goals of Monterey County, there is an expressed need to address these inequities as part of this program moving forward. Additional areas for improvement include the following: a) Assess current level of need by assessing each client with the Recovery Needs Level instrument; b) Discharge to lower levels of clinical service measured by the Recovery Needs Level Instrument; and c) Measure quarterly progress in Recovery by the Recovery Markers Inventory and the Consumer Recovery Markers.
PROGRAM DESCRIPTION

The Dual Recovery Services (DRS) program is an outpatient program for adults with co-occurring serious mental illness and substance use disorders. The program aims to assist clients in developing dual recovery skills to maintain successful community living, and to promote a clean and sober lifestyle as they transition out of dual recovery residential programs. Services include individual and group counseling to help clients develop skills to adjust to community living and/or maintain housing through the evidenced based practice of Motivational Interviewing. Clients develop goals that are focused on increasing daily structure, improving symptom management skills, personal and social functioning, and substance use recovery skills. Individual written service plans are developed for each consumer moving into this phase of community based treatment and help teach consumers how to avoid drug and alcohol use while strengthening healthy social supports using wellness and recovery principles.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of the Dual Recovery Services program is to reduce the length of stay at the Bridge House dual recovery residential program. The program works to increase the support to consumers as they move into the next phase of their wellness and recovery treatment in the community, and to promote a clean and sober lifestyle for adults and Transition Age Youth (TAY) in the MCBH Adult & TAY Systems of Care. Client level outcomes are monitored and documented in the Avatar electronic medical records system.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Dual Recovery Services program served 105 clients. Of clients served, 41% of were Latino and 12% were from South County. When combined, these figures represent a very modest contribution towards meeting our health equity goals in Monterey County, with racial equity figures being below the goal of 75% Latino engagement and regional equity figures being below the goal of 20% engagement of South County residents.
SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 47% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA Plan period, seeking alternative and complimentary funding sources will remain an objective of this program. As this program demonstrated challenges in meeting the health equity goals of Monterey County, there is an expressed need to address these inequities as part of this program moving forward. Additional areas for improvement include the following: a) Review the number of groups per week and the number of participants in each group; and b) Evaluate whether there is capacity to hold groups in Salinas, Marina, King City and/or Soledad.
ACCESS – GENERAL SYSTEM DEVELOPMENT

PROGRAM NAME: COMMUNITY PARTNERSHIP - HIV/AIDS

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>CSS – System Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>ACCESS Services</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Adult (26-59)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>Individuals and families affected by HIV/AIDS</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>Community Human Services</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Office locations in Salinas and Marina</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>9</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$295</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

The Community Partnership - HIV/AIDS provides outreach, engagement and specialized outpatient mental health counseling (individual, family and group) for those with HIV/AIDS and their significant others. In 2005, during a series of focus groups conducted throughout Monterey County for the initial 3-Year MHSA community program planning process, there were requests for specific services to address the significant mental health challenges related to having a diagnosis of HIV/AIDS. Services are provided in culturally and linguistically competent settings.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of this program is to improve mental and emotional health. Assessments of client outcomes utilizes a matrix evaluation tool specific to measuring mental health improvements in individuals living with HIV/AIDS. This program uses the Avatar electronic medical records system.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Community Partnership - HIV/AIDS served 9 clients. Of clients served, 55% of were Latino and none were from South County. When combined, these figures represent a very limited contribution towards meeting our health equity goals in Monterey County, with racial equity figures being below the goal of 75% Latino engagement and regional equity figures being below the goal of 20% engagement of South County residents.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 69% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA Plan period, seeking alternative and complimentary funding sources will remain an objective of this program. As this
program demonstrated challenges in meeting the health equity goals of Monterey County, there is an expressed need to address these inequities as part of this program.
PROGRAM DESCRIPTION

Return to Work Benefits Counseling is a service for adults and youth with mental health disabilities, along with their families and caregivers. The program operates out of the Central Coast Center for Independent Living (CCCIL) office in Salinas and also meets clients in the community throughout the Monterey County region, including South County. The Independent Living Center is a cross-disability, consumer-centered advocacy organization that believes people with disabilities should have the same civil rights, options and control over choices in their own lives as do people without disabilities. All direct service staff and most of the administrative staff are bilingual in Spanish and English. Consumers receive financial and medical benefits counseling, individual advocacy, peer supports, housing assistance, independent living skills training, and assistive technology counseling to enable them to make informed decisions on employment, health care, disability and Social Security benefits. This program also conducts outreach events and provides referral services.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of this program is to increase the number of consumers returning to the workforce and increase the independence of consumers with disabilities by obtaining/retaining employment, financial and medical benefits. CCCIL is particularly interested in increasing the number of youth and latino participants receiving their services. Specific outcome measures tracked by this program include the number and demographics of individuals receiving referrals, types of referrals, and the number of outreach presentations conducted in Monterey County. Progress towards achieving these goals are recorded and assessed by regular reports and meetings with MCBH staff.
SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Return to Work Benefits Counseling program served 187 clients. Of clients served approximately 60% were Latino and 12% were from South County. When combined, these figures represent a modest contribution towards meeting our health equity goals in Monterey County, with racial equity figures being below the goal of 75% Latino engagement and regional equity figures being below the goal of 20% engagement of South County residents.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 100% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA Plan period, seeking alternative and complimentary funding sources will remain an objective of this program. As this program demonstrated a modest contribution towards meeting the health equity goals of Monterey County, there is an expressed, need to address these inequities as part of this program. Specifically, CCCIL plans to increase their services to residents of South County by providing services at MCBH’s King City clinic one day per week.
PROGRAM NAME: ACCESS OUTPATIENT SERVICES

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>CSS – System Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area:</td>
<td>ACCESS Services</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>All Ages</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>All Monterey County residents, particularly the traditionally unserved, underserved and inappropriately served.</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>Community Human Services</td>
</tr>
<tr>
<td>Service Location:</td>
<td>Salinas and Marina, Gonzales Service Site via MCBH</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English and Spanish</td>
</tr>
<tr>
<td>Estimated Annual Number of Clients Served:</td>
<td>590</td>
</tr>
<tr>
<td>Estimated Cost Per Client Served:</td>
<td>$1,036.99</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

Access Outpatient Services provides mental health counseling program for people of all ages with moderate to severe mental health issues. Community Human Services provides mainly individual and family counseling for a variety of mental and emotional health issues such as depression, anxiety, grief and loss, domestic violence, child abuse, body image, gender identity and dysfunctional family dynamics.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The program aims to improve mental and emotional health outcomes, improve functioning and improve relationships.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the Access Outpatient Services program served 590 clients. Of clients served, 46% were Latino and 2% were from South County. Individuals served through this program are limited to those referred by MCBH Access clinical staff and therefore, the ability of this program to attain the health equity goals for mental health services delivery, i.e. 75% Latino and 20% South County residents, is not entirely within the Contractor’s control.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 84% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. Within this 3-Year MHSA Plan period, seeking alternative and complimentary funding sources will remain an objective of this program.
**INNOVATION**

**PROGRAM NAME: JUVENILE SEX OFFENDER RESPONSE TEAM (JSORT)**

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>INN</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area</td>
<td>Juvenile Justice</td>
</tr>
<tr>
<td>MHSA Age Group</td>
<td>Children &amp; Youth (12-15) Transition Age Youth (16-21) on Juvenile Probation</td>
</tr>
<tr>
<td>Priority Population</td>
<td>Adolescents who have been identified with sexually acting out behaviors contributed by untreated complex mental health issues</td>
</tr>
<tr>
<td>Service Provider</td>
<td>Monterey County Behavioral Health</td>
</tr>
<tr>
<td>Service Location</td>
<td>Salinas</td>
</tr>
<tr>
<td>Languages served</td>
<td>English/Spanish</td>
</tr>
<tr>
<td>Number of Clients Served in FY16</td>
<td>46</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16</td>
<td>$5,738</td>
</tr>
</tbody>
</table>

**PROGRAM DESCRIPTION**

The Juvenile Sex Offender Response Team (JSORT) is a collaborative partnership between Monterey County Probation and MCBH, providing specialty mental health services to adolescents who have sexually offended. MCBH provides extensive forensic psychosexual assessments to youth who have been referred by Monterey County Probation and the Juvenile Courts for sexually acting out behaviors. During the assessment, the therapist is able to identify and then treat any underlying mental health issues that have contributed to, or are at the root of, any sexually acting out behaviors. Once these mental health issues are identified and it’s determined the youth can remain safely in the community, MCBH provides intensive outpatient treatment consisting of individual, group and family therapy, to build the tools needed to establish more adaptive prosocial behaviors, reduce recidivism and become a safe and more productive member of the community. Program clinicians utilize evidence-based practices such as Aggression Replacement Training, Being a Pro: A Prosocial Model for Problem Solving, and Motivational Interviewing. JSORT also meets as a multi-disciplinary team (MDT) that may include: Law Enforcement, Probation, Behavioral Health, Victim Advocacy, Public Defender, Defense Attorney, and the Director of the Child Abuse Prevention Council. The MDT meets monthly to review current cases, providing a “step down” approach to youth returning home from placement by identifying appropriate, community-based safety plans upon return to the home as well as providing therapeutic support and clinical intervention to the youth and family. The MDT also reviews any cases that may be pending the court process.

JSORT began as an MHSA Innovation Project in 2009, meeting a large unmet mental health need in the community. Collaborative efforts with Law Enforcement, the Juvenile Courts and MCBH have been so positive and effective that JSORT is being moved from Innovations to a Full Service Partnership in FY18.
PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of JSORT is to successfully and safely maintain these youth in the community, improve the overall mental health and emotional functioning of the affected youth and their families, reduce the need for residential care and/or a commitment to the Department of Juvenile Justice, and reduce the risk of re-offending. These outcomes are tracked by the use of the JSOAP-II (Juvenile Sexual Offender Assessment Protocol-II) and CANS (Child and Adolescent Needs and Strengths) Tool. As some of the youth initially began treatment when they were under 18 years old and then completed treatment at 18 years of age or older, there are challenges with evaluating risk in that, the JSOAP-II is only appropriate for youth under the age of 18 years old. Therefore, future efforts to improve these evaluation methods will include implementing risk assessment tools (JSOAP-II, STATIC99 and ERASOR for example) that are useful for adolescents AND Transition Age Youth (over 18 years old).

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the JSORT program served 46 clients. Of the clients served, 63% were Latino and 13% were from South County. Individuals served through this program are limited to those who commit these specific crimes and therefore may not mirror the health equity goals for general mental health services delivery, i.e. 75% Latino and 20% South County residents.

SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 65% of the total program budget. In addition to the MHSA funds services are billed through Medi-Cal, for all eligible clients. JSORT has increased its involvement in regional and state collaboratives through attendance and participation in the California Coalition of Sexual Offenders (CCOSO) monthly meetings. These meetings allow JSORT improved collaboration with other agencies throughout the state and keep the program updated on the most recent and cutting edge research and treatment strategies in the field.
PROGRAM NAME: POSITIVE BEHAVIORAL INTERVENTION & SUPPORTS (PBIS)

<table>
<thead>
<tr>
<th>MHSA Component – Service Category</th>
<th>INN</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBH Strategic Plan Service Area</td>
<td>Student Mental Health</td>
</tr>
<tr>
<td>MHSA Age Group:</td>
<td>Children &amp; Youth (0-15)</td>
</tr>
<tr>
<td>Priority Population:</td>
<td>All school aged children (ages 5 to 18)</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>Monterey County Office of Education</td>
</tr>
<tr>
<td>Service Location:</td>
<td>This program serves all regions and all 25 school districts</td>
</tr>
<tr>
<td>Languages served:</td>
<td>English</td>
</tr>
<tr>
<td>Number of Clients Served in FY16:</td>
<td>400</td>
</tr>
<tr>
<td>Cost Per Client Served in FY16:</td>
<td>$25</td>
</tr>
</tbody>
</table>

PROGRAM DESCRIPTION

Positive Behavioral Intervention & Supports (PBIS) is a behavioral support system approach for instituting a decision-making framework and leadership team at both the district and school level to establish positive behavioral practices through training, coaching and data evaluation methods for improving behavior outcomes for all students. In FY 10-11, MCBH initiated the first PBIS program for participating school districts within Monterey County. In FY 12-13, MCBH, in partnership with the Monterey County Office of Education (MCOE), began planning the eventual implementation of PBIS throughout the Monterey County education system, resulting in MCOE acting as the lead agency for all PBIS implementations. MCOE began the implementation of PBIS for South Monterey County School Districts in 2015. There is a strong understanding that students do better in all areas of development, including social/emotional, when there is an improvement in school climate. The PBIS program hopes to improve school climate which will reduce the number of students referred for social/emotional problems, particularly anxiety and depressive disorders. MCBH has partnered with all school districts to assist in the training and support of PBIS. This program met the goals of the initial Innovations project in FY 16.

PROGRAM GOALS AND EVALUATION METHODOLOGY

The goal of PBIS is to improve students’ quality of life and school success by providing multi-tiered systems of intervention and support focused on improving social/emotional development. Anticipated outcomes for this program include less stigma toward those with mental health issues and those attempting to access services, lower dropout rates, less bullying, higher college enrollment and less substance use. Progress towards achieving the above goals are assessed using the Tiered Fidelity Inventory to measure PBIS fidelity.

SERVICE DATA AND IMPACT ON HEALTH EQUITY

In FY16, the PBIS program served 400 students. Of students served, 90% of were Latino and 100% were from South County. When combined, these figures represent a very strong contribution towards meeting our health equity goals in Monterey County, with racial equity figures being exceeding the goal of 75% Latino engagement and regional equity figures exceeding the goal of 20% engagement of South County residents.
SUSTAINABILITY AND STRATEGIES FOR IMPROVING SERVICE DELIVERY

In FY16, MHSA funds accounted for 50% of the total program budget. MCBH values the ability of programs to leverage resources and secure sustainable funding sources. MCOE’s PBIS Coordinator is working with the PBIS regional program in Santa Clara for technical assistance and guidance in developing and implementing a fiscally sustainable model for the PBIS programs in Monterey County. The MCOE PBIS/BH partnership will continue within shared efforts in improving school climate in Monterey County schools, however, funding provided by MCBH will discontinue in FY 18-19.
MOVING FORWARD: FY18-20 MHSA PROGRAM PLAN
PREVENTION

PEI-01: OPEN ACCESS WELLNESS CENTERS

Community feedback has indicated the need for neighborhood based wellness centers where community members can access resources and social support in non-stigmatizing settings. In response to this need, MCBH is dedicating PEI funding to community based organizations to operate wellness centers that will be open to all community members and will focus on providing information, on-site support to address needs and linkages to other entities that provide additional resources. The following two wellness centers have been developed with community input and have been providing much needed supports for our community. The OMNI Wellness Center provides holistic supports to adult consumers and welcomes all individuals to participate in events and programming. The Epicenter was created to support youth who have experienced adverse life events as well as offer information, socialization and developmentally appropriate programming for all Monterey County youth ages 16-25. Each center will be tailored to the population served and will be directed by consumers, peers, youth and family members.

PEI-01 PROJECTS/ ACTIVITIES/ PROGRAMS

1.1 The OMNI Resource Center provides activities and programs that focus on increasing positive mental health and overall wellness of individuals and the community by providing wellness awareness and innovative programs. The center serves to assist individuals in pursuing personal and social growth through self-help groups, socialization groups, and peer support groups. Additionally, the center offers skills and tools to those who choose to become leaders among their peers to take an active role in the wellness and recovery movement through various initiatives. The center also works to help individuals find a meaningful role in their community, to gain self-empowerment, to learn advocacy and leadership skills.

1.2 The Epicenter is an open, youth led resource center and welcomes all Monterey County Transition Age Youth (TAY) ages 16-25. Focused services and case management are provided to vulnerable TAY populations in Monterey County, including current/former foster youth, LGBTQ youth, and youth who have been involved with public agencies, such as Juvenile Probation and Mental Health. The center provides drop-in appointments, a variety of experiential learning opportunities such as workshops, and special events, along with referrals and access to services that support independent living skills. These include: peer support, information and referrals, food assistance, computer access, job boards and resource connections. The center provides space for community agencies to co-locate staff and services so that youth can have direct connections to needed supports that they may not access otherwise. In addition, the Epicenter fosters youth development and mentors youth to take leadership roles at the center with youth staff directing the majority of program operations. A youth leadership team has also been developed to provide leadership and feedback related to better serving individuals who identify as LGBTQ. Additionally, Epicenter staff and youth volunteers provide support to LGBTQ youth and training to Behavioral Health and to the community.
PEI-02: FAMILY SUPPORT AND EDUCATION

The MHSA asserts the importance of incorporating the family perspective in mental health treatment. Research also supports that individuals with mental health issues do better when their families are involved with a developed understanding of mental health and wellness as well as holding a strength-based approach to the process of recovery. It is also empowering for family members to have increased knowledge and understanding of the community resources available to assist their loved one as well as for the family members.

Community feedback continues to identify the importance of providing psycho-education and parenting classes to parents and caregivers to help them optimize their child’s developmental potential and their family’s functioning. Additionally, education and support has been requested to address concerning behaviors and issues in children and teens to prevent behaviors from escalating and address early warning signs of mental health issues. PEI funding will support parenting education that addresses known and emerging community needs. Classes will need to be provided regionally with a focus in South County, conducted in Spanish and in English and be culturally appropriate for Latino families.

### PEI-02 PROJECTS/ ACTIVITIES/ PROGRAMS

| 2.1 | PEI funding covers the Family Support Groups program which was developed by MCBH in response to families in the community who were seeking additional support for themselves. Family Support groups are open to the community; all family members are welcome and they do not have to have a relative currently in treatment with MCBH. Families benefit from being able to receive psycho-education regarding mental illness as well as from the support of other family members who are experiencing similar issues related to caring for a loved one with mental illness. |
| 2.2 | The Multi-Lingual Parent Education Partnership offers 8-10 week evidence based parenting programs serving English and Spanish-speaking families in Salinas, Seaside, South County and North County. The program also aims to increase capacity for culturally and linguistically appropriate parent education opportunities in targeted areas of Monterey County by recruiting and training additional parent educators who represent the community. |
PEI-03: OUTREACH FOR INCREASED AWARENESS OF EARLY SIGNS OF MENTAL ILLNESS

One of the key themes identified during the strategic planning process and again during recent focus groups and community surveys is the need for increased education to the community on early warning signs of mental illness. Outreach efforts providing education and information on mental health needs to be presented in a culturally responsive manner to assist in decreasing stigma, particularly in the Latino community. PEI funds will support established non-profits that have effective strategies for providing community education on mental health issues.

<table>
<thead>
<tr>
<th>PEI-03 PROJECTS/ACTIVITIES/PROGRAMS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.1</strong></td>
</tr>
<tr>
<td><strong>3.2</strong> &amp; <strong>3.3</strong></td>
</tr>
<tr>
<td><strong>3.4</strong></td>
</tr>
<tr>
<td><strong>3.5</strong></td>
</tr>
</tbody>
</table>
families and couples. Goals of this organization are to engage youth and adults in treatment to keep them free of the juvenile justice and criminal justice systems, as well as prevent the need for emergency room/crisis unit visits and hospitalizations. The program provides tools to enable clients in taking charge of their lives, to prevent mental illness or any other psychological/emotional issues from becoming severe and disabling.
The stigma associated with mental health was frequently cited by community members as preventing them from using mental health services. Participants from recent focus groups emphasized the importance of education and outreach as a strategy to decrease stigma and increase awareness of the supports and treatments available for mental illness. In addition, local consumer advocacy asserts that the psychiatrically disabled community needs direct recipient representation in order to obtain services and programs that will better serve their needs. The MHSA highlights the importance of clients having the opportunity to share their behavioral health experience and to impact policy regarding behavioral health service delivery.

**PEI-04 PROJECTS/ ACTIVITIES/ PROGRAMS**

**4.1** PEI funds will continue to support “Success Over Stigma” (SOS). This program focuses on consumer involvement in planning and executing mental health services and anti-stigma messaging in the community. To address stigma on a systemic level, SOS promotes consumer involvement in advocating for public policies that support and empower people with psychiatric disabilities. SOS also provides peer consultation to service providers, including increasing peer involvement in developing and strengthening mental health services both locally and at the state level. Additionally, consumers learn how to better advocate for themselves by providing reciprocal peer support and advocacy in their community.

**4.2** The California Mental Health Services Authority (CalMHSA), was created by the counties in 2010 to administer MHSA PEI projects on a statewide basis. In the initial phases, population-based strategies designed to prevent mental illnesses from becoming severe and disabling through outreach to recognize the early signs of mental illness, reduce stigma associated with mental illness and service seeking, and reduce discrimination against people with mental health challenges were developed and implemented through the financial contributions of participating counties. Phase III activities will focus on the implementation of statewide social marketing campaigns and related programs, with an emphasis on reaching Latino communities throughout California. The following are some of the activities to be implemented in Phase III: 1) actively engage communities through social media in Each Mind Matters/SanaMente; Know the Signs/Reconozca Las Senales: Walk In Our Shoes/Ponte En Mis Zapatos and Directing Change; 2) Create new culturally-adapted Spanish-language stigma reduction and/or suicide prevention outreach materials; and 3) Provide mini-grants to local CBOs serving Latino and other diverse communities.
**PEI-05: PREVENTION/PEER SERVICES TO OLDER ADULTS**

Seniors are often at increased risk for anxiety and depressive disorders due to co-occurring chronic medical conditions, isolation and financial challenges. Older adults (those 65+) in the Monterey county comprise 10% of the population but account for 25% of suicides. PEI funding will continue to support services for seniors as they are a vulnerable population with specialized needs.

**PEI-05 PROJECTS/ ACTIVITIES/ PROGRAMS**

| 5. 1 | The Seniors Council Senior Companion Program serves Santa Cruz, San Benito, Monterey and Santa Clara Counties. The program recruits, trains and places Senior Companions to work with homebound clients and clients who live alone, clients with chronic disabilities, clients whose caregiver needs respite from their responsibilities, clients with mental health issues and clients who are visually or hearing impaired. The program works to assist clients served by Senior Companions to maintain independent living and achieve the highest quality of life possible. |
| 5. 2 | The Senior Peer Counseling Program (SPC) provides no-cost mental health intervention and emotional support to older adults suffering from depression, anxiety, grief, loss, adjustment to chronic illness, and other stressors that can occur in the latter third of life. Peer Counselors, trained and supervised by mental health professionals, provide short-term one-on-one counseling that may be home-based, office-based, or at long term-care facilities. Volunteers and staff facilitate support groups that foster emotional support, encouragement, self-empowerment and connection to others. A small but strong core group of eight bi-cultural, bi-lingual Latino Senior Peer Counselor volunteers co-facilitate support groups and provide one-to-one peer counseling in the Salinas area. The group was trained with Spanish language curriculum and works under the supervision of a bi-lingual, bi-cultural clinician with extensive experience serving the Latino community. |
PEI-06: SUICIDE PREVENTION

Nearly everyone is touched by suicide at least once in their lifetime. In 2014, Monterey County experienced 57 suicides; the youngest was 15 and the oldest was 96. The Monterey County Community Health Assessment (2013) reviews of mental health indicators affirm the need for continued suicide prevention and intervention activities. Local data showed there was a significant increase in suicide among residents age 45-64, especially males, and that suicide rates for females more than doubled from 1999-2001 to 2008-2010.

PEI-06 PROJECTS/ACTIVITIES/PROGRAMS

6.1 PEI funding will support Suicide Prevention Service, a program of Family Service Agency of the Central Coast, serving Monterey, Santa Cruz, and San Benito residents since 1967. The primary mission is to identify high-risk individuals, families, and groups and provide them with safe alternatives to suicidal behavior. Their integrated method of service delivery includes a 24/7/365 free, multi-lingual suicide crisis line, educational outreach and training, and bereavement support services for those who have lost a loved one to suicide. Outreach personnel are also trained to offer a variety of training programs for community groups including: ASIST, SafeTalk, and Mental Health First Aid.
**Early Intervention**

**PEI-07: Access Regional Services**

During recent community focus groups, MCBH collected feedback on barriers and challenges faced by Monterey County residents when accessing mental health treatments services, along with constructive insights on finding resolutions to improve access and quality of care. Participants also offered insight on where and how they might feel more comfortable, and how they see more investment in community outreach, stigma reduction and prevention as top priorities. As there are a range of issues and a variety of needs in our community, PEI funding will be provided to diverse community based organizations who have demonstrated creative strategies to address the challenges and barriers community members have faced when accessing mental health treatment.

<table>
<thead>
<tr>
<th>PEI-07 Projects/ Activities/ Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7.1</strong> CSUMB’s Chinatown Community Learning Center (CCLC) collaborative offers qualified Master of Social Work (MSW) interns to provide support for the homeless and other marginalized populations in the Chinatown neighborhood of Salinas at the Chinatown Community Learning Center. The CCLC is a resource center with office and classroom space. The Center’s staff provides structured learning opportunities, access to social services, and supports the development of micro-enterprise activities that serve the needs of the homeless and marginalized in Chinatown, many of whom are also struggling with mental health and addiction issues.</td>
</tr>
<tr>
<td><strong>7.2</strong> The main goal of the Veteran’s Reintegration Transition Program (VRTP) is to provide education and awareness to veterans, their dependents and survivors on entitled benefits to include mental health services in the community. Additionally, this program seeks to streamline the process of transitioning service member veterans and their eligible dependents to health care, mental health care, education, employment and other community based services.</td>
</tr>
<tr>
<td><strong>7.3</strong> 2-1-1 Monterey County was launched February 2009 as a program of United Way Monterey County. 2-1-1 is a phone number, but also a system for connecting people quickly and efficiently to social and health services they are seeking, including mental health treatment and services. The phone is the most common method of contact with resource information also available via website. The service is available 24 hours a day/7 days week in 170 languages. Callers will reach a Call Specialist who has been highly trained, certified to assist, and be proactive in meeting their needs. Based on the nature of the conversation between caller and the Call Specialists, appropriate programs are brought to the attention of the caller. Additionally, 2-1-1 is used during times of natural or manmade disasters as a “go-to” number for anyone in the public to use to acquire the latest official information and as a feedback loop from the public to county officials.</td>
</tr>
</tbody>
</table>
The following needs were identified by the community during the Behavioral Health strategic planning process: increase prevention services, i.e., early intervention services and support in the schools, increase services to Medi-Cal beneficiaries in the general education population, increase family support and counseling services, increase the provision of group services to efficiently meet the increasing demand for student Mental Health services. MHSA funds support the following two programs that are addressing the above needs.

### PEI-08 PROJECTS/ ACTIVITIES/ PROGRAMS

| 8. 1 | Pajaro Valley Prevention and Student Assistance (PVPSA) serves Monterey County children and their families attending schools in the North Monterey County area (Pajaro/Las Lomas) who are Medi-Cal eligible and require mental health services. The goal of the MHSA funded PVPSA school counseling program is to assist children with developing coping skills to manage their impairment(s) and to function in day-to-day life and overall academic performance. A key component of this program is the placement of mental health counselors at each school site. A dedicated PVPSA office is found in each school served and the mental health counselor participates as a key member of the school team. The mental health counselor provides a family therapy approach to services and engages caregivers/parents to ensure progress in their child’s treatment. To address reducing barriers to care, PVPSA has a bi-lingual/bi-cultural case management specialist to support counselors with providing transportation and linkage to support services as needed. |
| 8. 2 | Harmony At Home’s Sticks & Stones School-Based Counseling Program is a prevention program for children exposed to violence and trauma in Monterey County. The program provides short-term intervention focusing on reducing stigma surrounding domestic violence and mental health issues, while also improving child and family functioning. Group counseling is provided by MFT/MSW interns/trainees in selected schools for children who have witnessed domestic violence. Most recent schools served were in Alisal Union School District, Salinas Elementary School District and Salinas Union High School District. Additional program activities include outreach and engagement activities conducted with community groups and organizations to further promote the program and availability of services. |
PEI-09: JUVENILE JUSTICE DIVERSION

Behavioral Health staff works with many community based service providers to create a collaborative network to meet the needs of at-risk youth and juveniles involved in the justice system. This network increases public safety, reduces recidivism, and promotes positive youth development. Community feedback from the strategic planning process identified the following priorities to better address the needs of youth who are at risk of becoming involved in the legal system due to unmet mental health needs and exposure to community violence: enhance trauma-informed treatment services, provide crisis services to families of youth homicide victims, increase services to family members and support youth needing help in obtaining employment. MHSA funds the following two community based programs that are addressing the above needs and community priorities.

### PEI-10 PROJECTS/ ACTIVITIES/ PROGRAMS

<table>
<thead>
<tr>
<th>9.1</th>
<th>Silver Star Resource Center is a multi-agency collaborative offering gang prevention and outpatient mental health services to at-risk youth prior to their involvement with the Juvenile Justice System. Behavioral health services at Silver Star Resource Center are provided to youth that are demonstrating first signs of emotional/behavioral issues that are affecting their education, family, and/or social well-being. The purpose of the program is an attempt to identify and treat the underlying mental health issues that may lead to more complex problems within the community and contribute to later involvement in the Juvenile Justice System. Goals of this program include: ongoing coordination of community resources, promoting healthy family environments, and reducing recidivism of criminal activity.</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.2</td>
<td>The Seaside Youth Diversion Program is a collaborative partnership between Seaside Police Department, Monterey County Probation, and MCBH in an effort to identify and treat underlying mental health issues in at-risk youth that may lead to more complex problems within the community and contribute to later involvement in the Juvenile Justice System. The MHSA funding supports a half-time Psychiatric Social Worker position used to provide an array of evidence based practices (Aggression Replacement Training, Motivational Interviewing, 7 challenges, Seeking Safety and Matrix) offered through individual, group and family treatment. Goals of this program include: ongoing coordination of community resources, promoting healthy family environments, and reducing recidivism of criminal activity.</td>
</tr>
</tbody>
</table>
Nationally there has been increased recognition of the importance of identifying and treating psychotic disorders. There is a growing body of evidence showing that treatment can be very effective in promoting positive outcomes for people who are experiencing early psychosis and in decreasing the negative impact of untreated psychosis in multiple areas of functioning. MHSA funding supports a local program that has demonstrated effective outcomes in our community, the Prevention and Recovery in Early Psychosis (PREP) program.

<table>
<thead>
<tr>
<th>PEI-10: PROJECTS/ ACTIVITIES/PROGRAMS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>10. 1</strong> The PREP Monterey program provides an integrated package of evidence-based treatments designed for remission of early psychosis among individuals age 14-35 who are demonstrating symptoms and functional impairments related to early psychosis and/or diagnosis of Schizophrenia or Schizoaffective Disorder. The core services include individual psychotherapy (Cognitive Behavioral Therapy for Psychosis - CBTp), strength-based case management, algorithm based medication management, Multi-family Groups (MFG), and educational and vocational support. PREP has a robust evaluation component to track mental health outcomes and key events, and includes cost savings projections based upon decreased hospitalization utilization and crisis mental health services for clients who are served in the program.</td>
</tr>
</tbody>
</table>
PEI-11: RESPONSIVE CRISIS INTERVENTIONS

Trauma informed care efforts have highlighted the need for service providers to effectively respond in a sensitive and developmentally appropriate manner to individuals who have been impacted by complex trauma. MHSA funding is supporting a unique program that is in place to support children who have been victims of sexual exploitation and abuse.

Additionally, the need to prevent psychiatric hospitalization and decrease the use of our emergency room and law enforcement for mental health crisis is becoming increasingly critical. The development of a mobile crisis response and stabilization program to stabilize children in mental health crisis, help families develop improved conflict resolution skills, communication skills, and develop plans for managing crisis in the future as well as prevent detention in juvenile facilities due to a mental health crisis is critically needed. When a child is suffering from a severe mental health crisis (suicidality or psychosis) inpatient psychiatric treatment can be an important component of a system of behavioral health care. Yet in many situations community based interventions would be more appropriate and prevent the disruption for children and families which result from hospitalizations.

<table>
<thead>
<tr>
<th>PEI-11 PROJECTS/ ACTIVITIES/ PROGRAMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.1</td>
</tr>
<tr>
<td>11.2</td>
</tr>
</tbody>
</table>
COMMUNITY SERVICES AND SUPPORTS - FULL SERVICE PARTNERSHIPS (FSP)

CSS-01: FAMILY STABILITY FSP

The following Full Service Partnerships (FSP) for children and families are designed to prevent out-of-home placement of children and youth whose emotional, social, and/or behavioral problems that create a substantial risk of placement in publicly funded care, such as foster homes, group homes, correctional institutions, or psychiatric facilities. These FSP’s provide a range of options for families, including a short-term crisis stabilization model, an integrated model involving Family and Children’s Services and MCBH and a specialized model focusing on Adoption Preservation. Research has shown that adoption disruptions can be prevented through the utilization of a continuum of adoption related services that include case management, therapeutic care, and skills acquisition training. With a focus on educating and empowering families to meet the needs of their children, even in high intensity situations, these programs can allow families to remain together.

CSS- 01 PROJECTS/ACTIVITIES/PROGRAMS

1. 1 Family Reunification Partnership is a unique and innovative program model that integrates Children’s Behavioral Health (CBH) therapists and Family and Children’s Services (FCS/DSS) social workers into one cohesive program to help families in the reunification process. The goal of the Family Reunification Partnership is to address the high intensity mental health needs of the children and families for improved individual and family functioning. This teaming approach is designed to improve coordination and collaboration among child welfare, mental health and other formal and informal supports, and children and families involved with the child welfare system. A CBH therapist is paired with a FCS/DSS social worker and they jointly share responsibility for case planning, provision of intensive therapeutic and support services, case monitoring, family team leadership, decision-making, and managing and leading orientation and other psycho-education groups.

1. 2 The Adoption Preservation FSP program addresses on-going needs of post-adoptive families. The goal of the Adoption Preservation program is to strengthen families and increase their level of attachment, efficacy, feelings of safety and psychological well-being to increase the permanency of adoption placements. In addition to decreasing costs for foster care placements, stabilizing family placements will help reduce the negative outcomes associated with children who grow up predominantly in foster care, including: poverty, teen pregnancy, juvenile delinquency, and lack of educational attainment. Families receive a team based, coordinated approach that includes a Child & Family Therapist and Family Support Counselor, access to psychiatrist, psychological assessment and occupational therapy services as needed. Parents are referred and encouraged to participate in parent education programs aimed at enhancing the impact of mental health intervention.
**CSS-02: DUAL DIAGNOSIS FSP**

Youth with acute mental health and substance abuse disorders often need intensive, focused treatments to address their complex needs. We have found that youth can be successful in their recovery and move ahead in their lives when they have access to a comprehensive array of services that are developmentally appropriate and strength based. This may involve moving into a positive living environment that allows them to feel safe and fully participate in their treatment and move ahead in their life goals. MHSA funding supports these critical programs for youth with co-occurring mental health and substance use disorders.

### CSS- 02 PROJECTS/ACTIVITIES/PROGRAMS

| 2. 1 | Integrated Co-Occurring Treatment (ICT) is a collaborative multi-agency effort to implement an effective approach to treating adolescents with co-occurring substance use and mental health disorders. The goals of ICT are to improve the overall functioning of the affected youth and their family and reduce the need for residential care. ICT is an intensive community-based program which provides an evidence based practice for adolescents and young adults in a strength based, home visitation model. ICT services often begin with home, school and/or community visits by staff, and continue throughout the treatment process. Working with adolescents and their families in their homes, school or community provides an invaluable basis for assessing and treating their individual needs. This program provides a comprehensive level of service that can range from helping adolescents with their socio-emotional well-being while assisting with obtaining and maintaining sobriety. ICT treatment is intensive and highly flexible (including evenings and weekends when required), and may also include psychiatric medication management. |
| 2. 2 | The focus of the Santa Lucia Residential Program is to identify, assess, and treat adolescent females in a residential facility who exhibit significant levels of co-occurring mental health and substance abuse needs. The goal of this program is to provide mental health and substance use disorder services while decreasing the risk of long term involvement with the Juvenile Justice System and out-of-home placements. Treatment addresses critical needs and issues including: serious emotional and behavioral disturbance, sexual exploitation, multiple foster care and/or residential placements, gang issues, exposure to community violence, substance abuse, complex and acute traumas. Intensive mental health services are provided in conjunction with psychiatric medication management as deemed clinically appropriate. Individual, family, or group therapies are designed to reduce mental health disabilities, and improve and maintain functioning consistent with the goals of learning, development, independent living and enhance self-sufficiency and family functioning. |
Monterey County works in partnership amongst public agencies and community partners in proving comprehensive programming for youth involved with MCBH, Juvenile Justice and/or the Department of Family and Children Services. Monterey County has taken advantage of funding opportunities to create a Mental Health Court for youth and has utilized MHSA Innovations funding to create a specialized program to address the previously unmet mental health needs of juveniles who have committed a sexual offense when it is clinically indicated to work with them therapeutically. In addition, MCBH has worked with local agencies to provide a highly supportive residential facility that supports youth who have exited institutional and/or correctional facilities who need a high level of support to be successful in the community following their discharge. These progressive programs will be funded in part by MHSA funding.

### CSS-03 PROJECTS/ACTIVITIES/PROGRAMS

#### 3.1 The Juvenile Mental Health Court - Community Action Linking Adolescents (CALA) Program

The Juvenile Mental Health Court - Community Action Linking Adolescents (CALA) Program offers Probation, Juvenile Court and Behavioral Health supervision and support to youth and their families. As a FSP program, this team adopts a “whatever it takes” approach, in treating at risk youth and their families. The CALA Court Youth Program was originally implemented with a Juvenile Mentally Ill Offender Criminal Reduction Grant, and then sustained by Mental Health Services Act (MHSA) funding. This funding provided for the development of a Juvenile Mental Health Court, and to serve the mental health needs of youth who come into contact with the Juvenile Justice System. This multi-disciplinary team screens all youth who are in the field, and on probation, with the Massachusetts Youth Screening Instrument Version 2 (MAYSI-2). Services are provided by: Monterey County Behavioral Health, Children’s Services staff, Monterey County Court Services, and Monterey County Probation. Treatment Model(s) being used include: Brief Strategic Family Therapy, Seven Challenges, Aggression Replacement Training, (ART), and Motivational Interviewing.

#### 3.2 The Juvenile Sex Offender Response Team (JSORT)

The Juvenile Sex Offender Response Team (JSORT) is a collaborative partnership between Monterey County Probation and MCBH, providing specialty mental health services to adolescents who have committed a sexual offence. The goals of JSORT are to safely maintain the youth in the community, improve the overall mental health and emotional functioning of the affected youth and their families, reduce the need for residential care and/or a commitment to the Department of Juvenile Justice, and reduce the risk of re-offending. Extensive forensic psychosexual assessments are provided to youth who have been referred by Monterey County Probation and the Juvenile Courts for sexually acting out behaviors. A range of intensive outpatient therapies (individual, group and family) are provided to build the tools needed to establish more adaptive prosocial behaviors, reduce recidivism and become a safe and more productive member of the community. Program clinicians utilize evidence based practices such as Aggression Replacement Training (ART), Being a Pro: A Prosocial Model for Problem Solving, and Motivational Interviewing. JSORT also includes a multi-disciplinary team (MDT) with representation from: Law Enforcement, Probation, Behavioral Health, Victim Advocacy, Public Defender, Defense Attorney, and the Director of the Child Abuse Prevention Council. The MDT meets to review cases and to ensure there is coordination of services and adequate oversight of the youth.

#### 3.3 The Incarceration to Success (I2S) Program

The Incarceration to Success (I2S) Program is a multi-agency collaborative effort that provides transitional housing for male transition age youth (TAY) who are exiting the Monterey County
Youth Center, involved with Juvenile Probation and MCBH, unable to return home, and are in need of stable housing with independent living coaching. The goals of this program are for successful transition by TAY into independent living, being free of criminal offenses with increased mental health stability and improved overall functioning in the community. Youth are taught independent living skills, job skills and case management services that support their mental health needs and increase their ability to live independently while reducing the risk of recidivism. Intensive case management services, groups, and therapeutic treatment teamwork and collaboration with county agencies allows the youth to engage in healthy community activities; teaching them how to build healthy relationships and allowing them to practice learned prosocial skills in their community.
CSS-04: TRANSITION AGE YOUTH  FSP

Transition Age Youth, ages 16 through 25, need developmentally appropriate mental health services and comprehensive supports for themselves and their family members as they transition from adolescence into early adulthood. Intensive supports are often needed to stabilize the youth who are experiencing symptoms of mental illness to avoid the need for emergency mental health services, such as Emergency Room visits and psychiatric hospitalizations. Co-occurring substance use is also common in this age group and can lead to negative consequences if left unaddressed. An FSP approach is needed for Transition Age Youth who are experiencing serious mental illness and MHSA funding will support the development of this program.

<table>
<thead>
<tr>
<th>CSS- 04 PROJECTS/ACTIVITIES/PROGRAMS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4. 1</strong> MCBH will provide a FSP model program for TAY who are experiencing symptoms of serious mental illness who need intensive services. In this program, goals are tailored to each youth, ranging from achieving educational or vocational pursuits, acquiring a stable living situation, and engaging with peer and social supports while also reducing symptoms of mental illness. Clients will be referred to community based agencies that provide education and employment assistance/supports and appropriate Day Treatment programs. The FSP will include peer youth mentors who have overcome similar mental health issues to help engage and keep youth in treatment. An evaluation component will be developed and FSP data will be reviewed to assess treatment gains.</td>
</tr>
</tbody>
</table>
The primary goal of the Adult System of Care is to provide a range of services and supports to Adults and Older Adults with serious mental illness in reaching their recovery goals and live in the least restrictive environment as possible. During the strategic planning sessions, the need for supportive housing options for adults, especially those involved in the criminal justice system, those experiencing homelessness or who are at high risk of homelessness, and older adults with serious mental illness and complex medical needs and/or physical disabilities, were identified as priorities. The following Full Service Partnerships are designed to meet these goals and respond to these priority community needs:

**CSS-05 PROJECTS/ACTIVITIES/PROGRAMS**

| 5.1 | The Creating New Choices Adult Mental Health Court Program, (CNC) is a collaborative effort between the Superior Court, Behavioral Health, Probation Department, District Attorney’s Office, Public Defender’s Office and the Sheriff’s Office to reduce the repetitive cycle of arrest and incarceration for adults with serious mental illness by providing intensive case management, psychiatric care, probation supervision and therapeutic mental health court. Adult Mental Health Treatment Court hearings with a Therapeutic Court Team (Judge, District Attorney and Public Defender along with Probation and CNC staff) are an integral part of the treatment program. CNC clients attend regular court hearings to review their progress in treatment including program participation, recovery work, personal accountability and prosocial behavior. Beginning in FY18, the CNC Team will also serve other clients that have current/recent Forensic involvement. |
| 5.2 | Intensive permanent and transitional supportive housing programs provide a Full Service Partnership level of services to very low-income individuals age 18 and older with a serious mental health diagnosis, all of whom are homeless or at high risk of homelessness. The service array includes assessments, evaluation, case coordination, intensive case management, assistance in accessing benefits, and assistance with daily living skills to help consumers meet the terms of their lease, and transition to live independently in the community. The goal is to prevent further homelessness, to avoid costly hospitalization or use of short-term crisis residential programs, hospital crisis teams, and unnecessary institutionalization in residential care homes, and instead to increase resilience and self-sufficiency. Permanent supportive housing programs provide housing to very low-income individuals with serious mental illness, many of whom are also homeless or at-risk of homelessness. The services array includes case management, crisis intervention, and mental health services for residents designed to minimize disability and maximize the restoration or maintenance of functioning. The goal of these programs is to assist these individuals to maintain safe, affordable, supportive permanent housing, and prevent further homelessness, to avoid costly hospitalization or use of short-term crisis residential programs, hospital crisis teams, and unnecessary institutionalizations. |
| 5.3 | Community outreach is provided to adults with a psychiatric disability who are homeless or at high risk of homelessness, and engage them in intensive case management, mental health services, shelter/housing support and assistance with daily living skills, provided in the FSP model. This program assists adults with mental illness, including those served by the public mental health system, to move off the street into housing and employment and/or onto benefits. The program... |
The goal is to prevent further homelessness, to avoid costly hospitalization or use of short-term crisis residential programs, hospital crisis teams, and unnecessary institutionalization in residential care homes.

| 5. 4 | For adults with serious mental illness, which can also include those with a co-occurring substance use disorder, FSP services will be offered as an intensive outpatient alternative to the array of residential treatment services and housing-based FSPs that often have long wait lists for entry to services. Services include mental health services, medication management, and case management to minimize the use of emergency services. This FSP will assist consumers who are living in residential care homes to maintain their placement and work towards a more independent living situation in the community. |
CSS-06: OLDER ADULTS FSP

The primary goal of the Adult System of Care is to provide a range of services and supports to Adults and Older Adults with serious mental illness in reaching their recovery goals and to live in the least restrictive environment as possible. During the strategic planning sessions, the need for supportive housing options for older adults, especially those experiencing homelessness or who are at high risk of homelessness, and older adults with serious mental illness and complex medical needs and/or physical disabilities, were identified as priorities. The following Full Service Partnerships are designed to meet these goals and respond to these priority community needs:

<table>
<thead>
<tr>
<th>CSS- 06 PROJECTS/ACTIVITIES/PROGRAMS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6. 1</strong> The Older Adult FSP provides intensive and frequent services for older adults with serious mental illnesses and complex medical issues who are at risk of losing their community placement, hospitalization, institutionalization, and homelessness. These outpatient services are focused on reducing unplanned emergency services and admissions to inpatient psychiatric hospitals, as well as preventing out of county and locked placements, which enhances the quality of life for these older adults.</td>
</tr>
<tr>
<td><strong>6. 2</strong> The Drake House Program serves older adults who have co-occurring mental health and physical conditions. This residential program assists residents with medication, medical appointments, daily living skills, money management, and provides structured activities daily. Services are designed to decrease symptoms or behaviors that can result in the utilization of higher levels of care and provides maximum level of supervision. A Wellness/Recovery program to reduce the incidence of co-morbid diseases, such as obesity, diabetes, high blood pressure and substance misuse is integrated into the overall treatment program. The goal of the Drake House program is to reduce psychiatric hospitalizations and maintain the client in the program which enhances their quality of life and increases socialization. This allows the clients to live in the least restrictive level of care.</td>
</tr>
</tbody>
</table>
COMMUNITY SERVICES AND SUPPORTS – GENERAL SYSTEM DEVELOPMENT (NON-FSP) PROGRAMS

CSS-07: ACCESS REGIONAL SERVICES

Providing community based mental health services that are easily accessible for individuals and families in all regions of Monterey County is a priority of MCBH. MHSA funding will support MCBH ACCESS clinics and community based organizations to provide regionally based services to address the needs of our community.

CSS-07 PROJECTS/ACTIVITIES/PROGRAMS

7.1 ACCESS clinics function as entry points into the Behavioral Health system. ACCESS programs serve children, youth and adults, and offer walk-in clinics in four regions of the county to provide early intervention and referral services for mental health and substance use issues. ACCESS clinics are located in Marina, Salinas, Soledad and King City. ACCESS provides a bi-lingual (English/Spanish) toll-free line available for speaking with a Social Worker and who will utilize a translator if the caller speaks another language. Welcome and Orientation groups are held at each regional site several times a week. The groups offer education about services, and brief assessments to refer individuals and families to services that will meet their needs. Services provided in ACCESS after an assessment may include 3-6 months of brief therapy, medication support, and case management. Medi-Cal beneficiaries are also referred to Community Human Services for therapeutic services at their community based clinics and if individuals need a higher level of care they are linked to more intensive services in MCBH Child and Adult Systems of Care.

7.2 The South County (King City) Clinic operated by the Kinship Center provides outpatient mental health services to eligible children and their families residing in the southern portion of Monterey County. The services are focused on promoting the mental health of children whose social and emotional well-being has been negatively impacted by loss and trauma associated with poor family functioning, abuse, neglect, domestic violence, parental incarceration and parental substance abuse. Mental health services refer to those individual, family or group therapies and interventions that are designed to reduce the incidence and risk of mental health disabilities, and improve and maintain functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency. These services are also intended to reduce the possibility of future residential care, periodic inpatient hospitalization, placement at out-of-state facilities, or placement in a juvenile justice facility.

7.3 The Community Partnership - HIV/AIDS provides outreach, engagement and specialized outpatient mental health counseling (individual, family and group) for those with HIV/AIDS and their significant others to improve their mental and emotional health.

7.4 The Village Project, Inc. was founded and opened its doors in May 2008 with a focus on providing services for African Americans and other underserved populations. The Village Project, Inc. is an all-encompassing agency in respect to the age groups for which it provides services and has
provided therapy for children and youth, adults, seniors, families and couples. Goals of this organization are to engage youth and adults in treatment to keep them free of the juvenile justice and criminal justice systems, as well as prevent the need for emergency room/crisis unit visits and hospitalizations. The program provides tools to enable clients in taking charge of their lives, to prevent mental illness or any other psychological/emotional issues from becoming severe and disabling.
CSS-08: EARLY CHILDHOOD MENTAL HEALTH

Extensive research has shown the importance of intervening with infants and young children when problems first arise and that parents/caregivers benefit from supportive therapies and psycho-education that increases their understanding of their children’s social emotional needs. Economists have demonstrated the cost saving benefits to our society if public funding is invested in children age 0-3 and their families. In the Behavioral Health Strategic Plan 2014, the community identified the need for increased mental health treatment for mothers/parents/caregivers of children 0-5 and increased services for families/caregivers of children served by behavioral health through collateral contact and family therapy. Community feedback has also highlighted the importance of providing services that are accessible and community based, including home visitation and therapy for families in their homes. MHSA funding supports the following program for children ages 0-5 and their families.

<table>
<thead>
<tr>
<th>CSS- 08 PROJECTS/ACTIVITIES/PROGRAMS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>8. 1</strong> The Secure Families/Familias Seguras program has, as its core value, the provision of culturally and linguistically appropriate behavioral health services for children ages 0-5 and their caregivers/family members to support positive emotional and cognitive development in children and increase caregiver capacity to address their children’s social/emotional needs. The goals of this program are to decrease mental health symptoms, increase ability of children to regulate emotions, and increase caregiver understanding and ability to respond to their children’s needs. Clients served in the program come from vulnerable families who have experienced trauma, poverty and disenfranchisement. Services include Dyadic Therapy (parent/caregiver and child), Parent-Child Interaction Therapy, Circle of Security Groups, Child Parent Psychotherapy, Developmental and Social-Emotional Screenings and case management to link families with community based resources. Services are provided in all regions of Monterey County, with a focus on South County, and include home visitation.</td>
</tr>
</tbody>
</table>

| **8. 2** MCSTART is a collaborative early intervention program that provides services for infants and children experiencing developmental delays and mental health problems caused by early childhood trauma, including neglect, abuse, violence, and/or prenatal exposure to alcohol and other drugs. The primary focus is to identify, assess, refer, and treat infants and children affected by the broad spectrum of developmental, social, emotional, and neurobehavioral disorders utilizing evidence-based practices and trauma-informed services. Goals of the MCSTART program include improvement of the child’s development and health, reduced mental health symptoms, increased school readiness and improved family functioning with a focus on placement stability. |
According to the Substance Abuse Mental Health Services Administration, among youth ages 18-25, the prevalence of serious mental health conditions is high, yet this age group shows the lowest rate of help-seeking behaviors. Those with mental health conditions in this age group have a high potential to minimize future disability if social acceptance is broadened and they receive the right support. During the strategic planning process the community identified the importance of providing more therapeutic services for youth and young adults so that more transition age youth (TAY) can participate and receive timely and effective services to meet their needs. Increased services for family members of TAY was identified as a need in addition to more substance abuse treatment and linkages to Vocational/Occupational training. MHSA funding supports the following Behavioral Health program for TAY which provides therapeutic services for youth ages 16-25.

**CSS- 09 PROJECTS/ACTIVITIES/PROGRAMS**

| 9. 1 | The TAY Avanza program provides mental health treatment and peer mentoring to youth and young adults ages 16 through 25 who have significant mental health disorders by providing therapy, groups, comprehensive case management and opportunities for positive social interactions. In this program treatment goals are tailored to each youth, with a general focus on decreasing mental health symptoms so the youth can have a stable, successful transition into adulthood. Individual goals can range from achieving educational or vocational pursuits, acquiring a stable living situation, and engaging with peer and social supports while also reducing symptoms of mental health challenges. The TAY Avanza program provides out-patient dual diagnosis treatment for youth with co-occurring substance use and mental health conditions and links youth with more severe co-occurring conditions to community resources that offer a higher level of care. Psycho-education and support is also provided to family members as they are an important part of a young adult's support system and are critical in their success. |
CSS-10: SUPPORTED SERVICES TO ADULTS WITH SERIOUS MENTAL ILLNESS

Behavioral Health staff collaborates with local agencies to provide supportive services to adults ages 18 years and older with serious and persistent mental illness who are served by the various programs in the Adult System of Care. During the strategic planning focus groups and community outreach sessions, a theme emerged around the difficulty navigating the Mental Health system. Community members expressed concerns about how to best access services. Additionally, many members of the community reported difficulty understanding how to access the benefits and services available to them.

CSS-10 PROJECTS/ACTIVITIES/PROGRAMS

10.1 Wellness Navigators (WNs), stationed at each Adult Services clinic, welcome clients into the clinic, help support completion of intake screening tools, and help clients understand the services available to them. They discuss services that suit each client’s recovery needs and help connect him/her to community-based resources that new clients need support in accessing. The WNs also follow up with a visit or phone call to continue linking clients to services.

10.2 The Peer Partners for Health is a voluntary training and peer support program focusing on clients who are either in the crisis residential program at Manzanita House and/or the Natividad Medical Center in-patient unit to help them with their transition into the community after they are discharged. This program was requested by consumers through Recovery Task Force. With the assistance of a WN team, consisting of a peer and a family member, consumers are connected to community-based follow up services in a culturally sensitive manner. The program aims to decrease frequency of mental health crises by increasing support in the home to include symptom management skills training, education on mental health and connecting clients to community resources.

10.3 CSS funds are to be allocated for System Development purposes in supporting permanent supportive housing programs, which provide housing to very low-income individuals with serious mental illness, many of whom are also homeless or at-risk of homelessness. The services array includes case management, crisis intervention, and mental health services for residents designed to minimize disability and maximize the restoration or maintenance of functioning. The goal of these programs is to assist these individuals to maintain safe, affordable, supportive permanent housing, and prevent further homelessness, to avoid costly hospitalization or use of short-term crisis residential programs, hospital crisis teams, and unnecessary institutionalizations.

10.4 Return to Work Benefits Counseling supports adults and Transition Age Youth with mental health disabilities, to increase the number of consumers returning to the workforce and increase independence. Consumers receive financial and medical benefits counseling, individual advocacy, peer supports, housing assistance, independent living skills training, and assistive technology counseling to enable clients in making informed decisions on employment, health care, disability and Social Security benefits.
CSS-11: DUAL DIAGNOSIS

Women and children who are impacted by substance abuse, mental health conditions, trauma and domestic violence need intensive and cohesive supports to have the best chance of recovering and increasing stability in their families. Families that are impacted by substance abuse and co-occurring mental health conditions often have high rates of involvement with the Child Welfare System. When families can receive holistic treatment in a supportive environment the whole family has an opportunity to heal and progress together. If families can improve functioning and caregivers are able to care for their children then fewer children are placed in foster care. MHSA funding supports Nueva Esperanza, a residential facility for women and children that addresses these complex needs, as well as the Dual Recovery Services/Co-Occurring Disorders Integrated Care outpatient program for adults.

**CSS-11 PROJECTS/ACTIVITIES/PROGRAMS**

**11.1** Nueva Esperanza is a program for pregnant or parenting women over the age of 18 who are experiencing problems with alcohol and/or other drugs of sufficient severity necessitating the need for residential care for themselves and their young children. The goal of this program is to increase the woman's readiness and ability to change, to treat chronic mental health and substance abuse disorders, and educate these pregnant women and mothers of young children on the effects of alcohol, drug, and/or trauma exposure on the unborn or young child. Program services provide integrated interventions to treat both substance abuse and mental health disorders. To comprehensively address the wide-ranging issues impacting the women and children, Nueva Esperanza makes available a complete range of medical, psychological, recovery, dyadic, parenting, and other social services on either a programmatic, consultative, or referral basis. These services are provided in a warm and comfortable drug-free, non-smoking environment with private rooms for each individual family to promote cohesion and autonomy. Each resident is viewed as a unique individual and each family is seen from a strength-based approach.

**11.2** The Dual Recovery Services/Co-Occurring Disorders Integrated Care program is an outpatient program for adults with co-occurring serious mental illness and substance use disorders. The program aims to assist clients in developing dual recovery skills to maintain successful community living, and to promote a clean and sober lifestyle as they transition out of dual recovery residential programs. Services include individual and group counseling to help clients develop skills to adjust to community living and/or maintain housing through the evidenced based practice of Motivational Interviewing. Clients develop goals that are focused on increasing daily structure, improving symptom management skills, personal and social functioning, and substance use recovery skills. Individual written service plans are developed for each consumer moving into this phase of community based treatment and help teach consumers how to avoid drug and alcohol use while strengthening healthy social supports using wellness and recovery principles.
These General System Development programs for children and families are designed to prevent out-of-home placement of children and youth whose emotional, social, and/or behavioral problems that create a substantial risk of placement in publicly funded care, such as foster homes, group homes, correctional institutions, or psychiatric facilities. These programs compliment the Family Stability FSP programs by serving the same population where less intensive services are required along the continuum of care.

<table>
<thead>
<tr>
<th>CSS- 12 PROJECTS/ACTIVITIES/PROGRAMS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>12.1</strong> The Family Preservation program is an intensive, short-term, in-home crisis intervention and family education program designed to prevent out-of-home placement of children whose emotional, social, and/or behavioral problems create a substantial risk of placement in publicly-funded care, such as foster homes, group homes, correctional institutions, or psychiatric facilities. Through in-home mental health intervention and psycho-education, this program enables parents/caregivers to meet the high needs of their children, build safer and more secure relationships within their family, and create a long term support system. This program encourages families to remain together, even in high intensity situations, as the focus is on educating and empowering families to meet the needs of their children. This now includes the Home Partners Program, which is an intensive, short-term, in-home crisis intervention and family education program designed to defuse the immediate crisis, stabilize the environment, and assist families to develop more effective parenting skills and coping abilities. The main program components include interventions at the crisis point, treatment in the client’s environment, 24-hour therapist availability and treatment that is highly individualized. Services are provided intensively and as needed, over a 4 to 6 week period. This program enables caregivers to meet the high mental health needs of their children; strengthening safe relationships within their family leading to a long-term support system.</td>
</tr>
<tr>
<td><strong>12.2</strong> Kinship Center’s Trauma Services Program provides outpatient mental health services to eligible children 0-5 and their families. Mental health services consist of those individual, family or group therapies and interventions designed to provide reduction of mental disability and improvement and maintenance of functioning consistent with the goals of learning, development, future independent living and enhanced self-sufficiency. The focus of the program is resolving trauma experiences for children, the impact of trauma on a child and his/her family, and the impact of trauma on children being raised by a relative caregiver. Such services help to reduce the possibility of future residential care, periodic inpatient hospitalization, placement at out-of-home facilities, or placement in a juvenile justice facility.</td>
</tr>
<tr>
<td><strong>12.3</strong> The Kinship Center D’Arrigo Children’s Clinic provides outpatient mental health services to eligible children and their families. Mental health services consist of individual, family or group therapies and interventions designed to reduce mental disability and improve/maintain functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency. The focus of the program is permanency for children, lessen the impacts of adoption on a child and his/her family, as well as the impacts on children being raised by a relative caregiver. Such services help reduce the possibility of future residential care, periodic inpatient hospitalization, placement at out-of-state facilities, or placement in a juvenile justice facility.</td>
</tr>
</tbody>
</table>
INNOVATION

INNOVATION PROJECT 1: MICRO-INNOVATION PROJECTS TO INCREASE THE NUMBER OF LATINO CLIENTS SERVED

The safety net population in Monterey County is comprised of 75% Hispanic/Latino beneficiaries. Over the last seven (7) years, Monterey County Behavioral Health has tracked the percentage of Latino beneficiaries served in our system. This percentage has consistently been between 50 to 54% Latinos, despite the fact that the total number of clients served has increased by 53% over this same period.

Additionally, in External Quality Review Organization (EQRO) audits, Monterey County has a lower Hispanic/Latino penetration rate than the statewide average.
As the safety net provider of mental health services in Monterey County, we have an obligation to ensure the equitable distribution of services. The data has clearly shown us that continuing services as usual will lead to a perpetuation of a service delivery system that fails to equitably meet the needs of the largest portion of our safety net population. We are prioritizing projects around engaging Latinos in response to the work done by our MHSA Evaluation Ad-Hoc Committee, which reviewed the community Focus Group session feedback and survey responses collected during the development of our FY18-20 MHSA 3-Year Program and Expenditure Plan. It is crucial for the county to engage in a very focused effort to identify methods to address inequity. We have worked in the past on projects designed for the Latino population, however, we have yet to allocate a significant amount of funds to develop and try out innovative approaches to improve the engagement of the Latino population in mental health services. We see in both our county staff and community providers a passion to improve equity. We want to create the opportunity to free up resources for small scale innovation approaches developed by individuals and groups in the community.

This Innovation project will build upon community feedback to test a minimum of twenty (20) different micro-innovation projects aimed at engaging new Latino beneficiaries in mental health services. Each micro-innovation project will test new methods of providing services or new ways to link Latino clients into services. Each Innovation project proposal will include a project plan formatted in the model for quality improvement testing that includes a Plan, Do, Study, Act or “PDSA”.

![HISPANIC/LATINO PENETRATION RATES](image)
INNOVATION PROJECT 2: SCREENING TO TIMELY ASSESSMENT INNOVATION

In Monterey County, the demand for services has greatly increased with our ACCESS programs serving 90% more individuals in the past two years, and a 168% increase in the last 5 years.

In order to better meet the increased demand for services, Monterey County Behavioral Health is seeking to develop innovative approaches to screening community members into the best level of care. Our community feedback process for the development of our FY18-20 MHSA 3-Year Program and Expenditure Plan indicated the community wants a stronger presence of Behavioral Health staff teaching them more about Behavioral Health in non-stigmatizing environments. The community wants to know what services are available and when/how they should seek these services. Additionally, in our meetings with the Promotores, they indicated needing support in learning about who should be moved to a higher level of care.

By developing a web-based screening tool that is culturally appropriate and meets the needs of the Spanish speaking population, we will be able to help people understand their potential needs and quickly connect them to needed treatment. In the past, we have tested other screening tools but have yet to find something that meets our core criteria for success which includes:

1. The assessment must work fluidly in Spanish;
2. The tool must screen for a broad range of disorders from mild depression to people with intensive needs such as schizophrenia;
3. The tool must be easily accessible so it can be used by community based providers to support people getting into treatment;
4. The tool must maintain confidentiality standards and interface with our electronic medical record so we can provide seamless transitions into care; and,
5. The tool must build upon current evidence based screening tools with proven validity, as well as utilize item response theory, so the community member is required to only answer the minimum number of questions possible and is not burdened by a lengthy assessment.
INNOVATION PROJECT 3: TRANSPORTATION COACHING BY WELLNESS NAVIGATORS

This Innovation project is designed to facilitate consumer accessibility (i.e. transportation) to critical services. Community stakeholders, county staff, family members and the people who receive mental health services in Monterey County have consistently shared the challenges many clients experience with transportation. In our Behavioral Health Strategic plan, every one of our fifteen (15) stakeholder groups identified transportation as a key issue of concern. During our MHSA Community Program Planning process, again the community listed transportation as a key barrier to care. While Monterey County Behavioral Health provides transportation to at least 150 consumers a week in our Adult System of Care alone, our current efforts to transport clients fall short of meeting the community demand. Based on community feedback, our proposed Innovation project involves developing an assessment of consumers’ needs and hiring transportation coaches who will help community members to access current transportation resources which can be difficult to navigate.

Behavioral Health will work with our Consumer Advisory Task Force to develop a transportation needs assessment that clearly identifies each consumer’s current needs and capabilities. After the assessment is completed, a web based training curriculum will be developed and implemented that teaches “Wellness Navigators” (employees with lived experience) to help clients get their transportation needs met and develop skills to become more independent. Wellness Navigators will work out of each regional clinic ensuring clients are able to come to both behavioral health and primary care appointments. Wellness Navigators will help the client access alternative approaches to getting to their appointments utilizing public transportation, bus tickets, taxi vouchers, and their own cars. One example of an intervention that Wellness Navigators will be trained on includes taking the bus with clients to learn how to understand the system and reduce fears associated with using this public system.

In addition, the Wellness Navigators will provide a range of peer support services to encourage increased recovery activities and connections to community resources. These enhanced recovery services will focus more on supported employment, supported education, mental health and substance use recovery groups, cultural and community events, as well as a range of social and fun activities.

This Innovation project will teach us if our Wellness Navigator interventions increase appointment attendance, improve client satisfaction with services and increase client transportation independence to support overall recovery goals.
COST PER CLIENT AND NUMBER OF CLIENTS SERVED BY PROJECT

**Prevention and Early Intervention**

<table>
<thead>
<tr>
<th>PROJECT</th>
<th>COUNT OF CLIENTS SERVED</th>
<th>ESTIMATED COST PER CLIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Access Wellness Centers</td>
<td>1,002</td>
<td>$694</td>
</tr>
<tr>
<td>Family Support and Education</td>
<td>881</td>
<td>$352</td>
</tr>
<tr>
<td>Outreach for Increased Awareness of Early Signs of Mental Illness</td>
<td>6,949</td>
<td>$144</td>
</tr>
<tr>
<td>Stigma and Discrimination Reduction&lt;sup&gt;3&lt;/sup&gt;</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Peer to Peer Services for Older Adults</td>
<td>356</td>
<td>$855</td>
</tr>
<tr>
<td>Suicide Prevention</td>
<td>7,044</td>
<td>$32</td>
</tr>
<tr>
<td>Access Regional Services</td>
<td>3,382</td>
<td>$57</td>
</tr>
<tr>
<td>Student Mental Health</td>
<td>470</td>
<td>$1,024</td>
</tr>
<tr>
<td>Juvenile Justice</td>
<td>52</td>
<td>$3,997</td>
</tr>
<tr>
<td>Prevention Recovery Early Psychosis</td>
<td>62</td>
<td>$8,065</td>
</tr>
<tr>
<td>Crisis Interventions</td>
<td>488</td>
<td>$994</td>
</tr>
</tbody>
</table>

**Community Services and Supports**

<table>
<thead>
<tr>
<th>PROJECT</th>
<th>COUNT OF CLIENTS SERVED</th>
<th>ESTIMATED COST PER CLIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Stability FSP</td>
<td>68</td>
<td>$17,685</td>
</tr>
<tr>
<td>Dual Diagnosis FSP</td>
<td>119</td>
<td>$10,835</td>
</tr>
<tr>
<td>Juvenile Justice FSP</td>
<td>68</td>
<td>$17,450</td>
</tr>
<tr>
<td>Transition Age Youth FSP</td>
<td>9</td>
<td>$90,642</td>
</tr>
<tr>
<td>Adult SMI FSP</td>
<td>300</td>
<td>$17,323</td>
</tr>
<tr>
<td>Older Adult FSP</td>
<td>34</td>
<td>$40,507</td>
</tr>
<tr>
<td>Access Regional Services</td>
<td>4,342</td>
<td>$2,710</td>
</tr>
<tr>
<td>Early Childhood Intervention</td>
<td>711</td>
<td>$3,894</td>
</tr>
<tr>
<td>Transition Age Youth</td>
<td>229</td>
<td>$3,708</td>
</tr>
<tr>
<td>Supported Services to SMI</td>
<td>245</td>
<td>$2,642</td>
</tr>
<tr>
<td>Dual Diagnosis</td>
<td>145</td>
<td>$7,047</td>
</tr>
<tr>
<td>Family Stability</td>
<td>161</td>
<td>$9,086</td>
</tr>
</tbody>
</table>

<sup>3</sup> “Stigma and Discrimination Reduction” provides marketing services with a diffuse impact that is not accurately quantifiable.
FY18-20 MHSA BUDGET NARRATIVE

This FY18-20 MHSA 3-Year Program and Expenditure Plan ("Plan") reflects continued funding for previously approved CSS and PEI components. Due to the uncertain financial climate, an overall expansion of programs would not be fiscally prudent nor sustainable at this time. Accordingly, the Plan aims to maintain services at the same or similar level as in FY17.

In response to the uncertainty around healthcare at the national level, the impending implementation of State initiatives such as No Place Like Home (NPLH), and the increasing costs of doing business at the local level, the Plan presented here reflects a conservative budgeting approach. That is, estimating revenues at the anticipated level to be realized, and adjusting expenditures accordingly to achieve a balanced budget that does not erode reserves intended to shore up finances during economic downturns.

Therefore, the current Plan includes a reduction in MHSA revenue equal to the estimated impact of the NPLH initiative, and an equivalent adjustment in MHSA expenditures. As the County anticipates costs will continue to increase sharply, it is likely that additional funding adjustments will be required to the expenditure plans in the last two years, FY19 and FY20, to balance the budget.
### PREVENTION AND EARLY INTERVENTION (PEI) COMPONENT WORKSHEETS

#### FY18-20 MHSA EXPENDITURE PLAN (BUDGET WORKSHEETS)

#### PEI Component Worksheets

<table>
<thead>
<tr>
<th>Prevention and Early Intervention (PEI) Component</th>
<th>Fiscal Year 2017/18</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>Estimated Total Mental Health Expenditures</td>
<td>Estimated PEI Funding</td>
</tr>
<tr>
<td><strong>PEI Programs - Prevention</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Open Access Wellness Center</td>
<td>695,789</td>
<td>695,789</td>
</tr>
<tr>
<td>2. Family Support and Education</td>
<td>310,541</td>
<td>310,541</td>
</tr>
<tr>
<td>3. Outreach for Increased Awareness and Early Signs of Mental Illness</td>
<td>1,002,659</td>
<td>766,385</td>
</tr>
<tr>
<td>4. Stigma and Discrimination Reduction</td>
<td>284,939</td>
<td>284,939</td>
</tr>
<tr>
<td>5. Prevention / Peer Services to Older Adults</td>
<td>304,204</td>
<td>304,204</td>
</tr>
<tr>
<td>6. Suicide Prevention</td>
<td>228,731</td>
<td>178,731</td>
</tr>
<tr>
<td><strong>PEI Programs - Early Intervention</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Access Regional Services</td>
<td>192,317</td>
<td>192,317</td>
</tr>
<tr>
<td>8. Student Mental Health</td>
<td>481,120</td>
<td>246,528</td>
</tr>
<tr>
<td>9. Juvenile Justice</td>
<td>207,849</td>
<td>54,291</td>
</tr>
<tr>
<td>10. Prevention and Recovery for Early Psychosis</td>
<td>500,000</td>
<td>303,000</td>
</tr>
<tr>
<td>11. Responsive Crisis Interventions</td>
<td>484,981</td>
<td>417,174</td>
</tr>
<tr>
<td><strong>PEI Administration</strong></td>
<td>96,996</td>
<td>96,996</td>
</tr>
<tr>
<td><strong>PEI Assigned Funds</strong></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Total PEI Program Estimated Expenditures</strong></td>
<td>4,790,127</td>
<td>3,850,896</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prevention and Early Intervention (PEI) Component</th>
<th>Fiscal Year 2018/19</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>Estimated Total Mental Health Expenditures</td>
<td>Estimated PEI Funding</td>
</tr>
<tr>
<td><strong>PEI Programs - Prevention</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Open Access Wellness Center</td>
<td>695,789</td>
<td>695,789</td>
</tr>
<tr>
<td>2. Family Support and Education</td>
<td>310,541</td>
<td>310,541</td>
</tr>
<tr>
<td>3. Outreach for Increased Awareness and Early Signs of Mental Illness</td>
<td>719,426</td>
<td>714,426</td>
</tr>
<tr>
<td>4. Stigma and Discrimination Reduction</td>
<td>284,939</td>
<td>284,939</td>
</tr>
<tr>
<td>5. Prevention / Peer Services to Older Adults</td>
<td>304,204</td>
<td>304,204</td>
</tr>
<tr>
<td>6. Suicide Prevention</td>
<td>228,731</td>
<td>178,731</td>
</tr>
<tr>
<td><strong>PEI Programs - Early Intervention</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Access Regional Services</td>
<td>192,317</td>
<td>192,317</td>
</tr>
<tr>
<td>8. Student Mental Health</td>
<td>481,120</td>
<td>246,528</td>
</tr>
<tr>
<td>9. Juvenile Justice</td>
<td>207,849</td>
<td>54,291</td>
</tr>
<tr>
<td>10. Prevention and Recovery for Early Psychosis</td>
<td>500,000</td>
<td>303,000</td>
</tr>
<tr>
<td>11. Responsive Crisis Interventions</td>
<td>484,981</td>
<td>417,174</td>
</tr>
<tr>
<td><strong>PEI Administration</strong></td>
<td>96,996</td>
<td>96,996</td>
</tr>
<tr>
<td><strong>PEI Assigned Funds</strong></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Total PEI Program Estimated Expenditures</strong></td>
<td>4,506,894</td>
<td>3,798,937</td>
</tr>
</tbody>
</table>
### Prevention and Early Intervention (PEI) Component

#### Fiscal Year 2019/20

<table>
<thead>
<tr>
<th>PEI Programs - Prevention</th>
<th>Estimated Total Mental Health Expenditures</th>
<th>Estimated PEI Funding</th>
<th>Estimated Medi-Cal FFP</th>
<th>Estimated 1991 Realignment</th>
<th>Estimated Behavioral Health Subaccount</th>
<th>Estimated Other Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Open Access Wellness Center</td>
<td>695,789</td>
<td>695,789</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2. Family Support and Education</td>
<td>310,541</td>
<td>310,541</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3. Outreach for Increased Awareness and Early Signs of Mental Illness</td>
<td>719,426</td>
<td>714,426</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5,000</td>
</tr>
<tr>
<td>4. Stigma and Discrimination Reduction</td>
<td>284,939</td>
<td>284,939</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5. Prevention / Peer Services to Older Adults</td>
<td>304,204</td>
<td>304,204</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6. Suicide Prevention</td>
<td>228,731</td>
<td>178,731</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>50,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PEI Programs - Early Intervention</th>
<th>Estimated Total Mental Health Expenditures</th>
<th>Estimated PEI Funding</th>
<th>Estimated Medi-Cal FFP</th>
<th>Estimated 1991 Realignment</th>
<th>Estimated Behavioral Health Subaccount</th>
<th>Estimated Other Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Access Regional Services</td>
<td>192,317</td>
<td>192,317</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>8. Student Mental Health</td>
<td>481,120</td>
<td>246,528</td>
<td>142,592</td>
<td>0</td>
<td>92,000</td>
<td>0</td>
</tr>
<tr>
<td>9. Juvenile Justice</td>
<td>207,849</td>
<td>54,291</td>
<td>131,240</td>
<td>0</td>
<td>22,318</td>
<td>0</td>
</tr>
<tr>
<td>10. Prevention and Recovery for Early Psychosis</td>
<td>500,000</td>
<td>303,000</td>
<td>197,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>11. Responsive Crisis Interventions</td>
<td>484,981</td>
<td>417,174</td>
<td>37,375</td>
<td>0</td>
<td>0</td>
<td>30,432</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PEI Administration</th>
<th>Estimated Total Mental Health Expenditures</th>
<th>Estimated PEI Funding</th>
<th>Estimated Medi-Cal FFP</th>
<th>Estimated 1991 Realignment</th>
<th>Estimated Behavioral Health Subaccount</th>
<th>Estimated Other Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>96,996</td>
<td>96,996</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PEI Assigned Funds</th>
<th>Estimated Total Mental Health Expenditures</th>
<th>Estimated PEI Funding</th>
<th>Estimated Medi-Cal FFP</th>
<th>Estimated 1991 Realignment</th>
<th>Estimated Behavioral Health Subaccount</th>
<th>Estimated Other Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### Total PEI Program Estimated Expenditures

<table>
<thead>
<tr>
<th>Estimated Total Mental Health Expenditures</th>
<th>Estimated PEI Funding</th>
<th>Estimated Medi-Cal FFP</th>
<th>Estimated 1991 Realignment</th>
<th>Estimated Behavioral Health Subaccount</th>
<th>Estimated Other Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>4,506,894</td>
<td>3,798,937</td>
<td>508,207</td>
<td>0</td>
<td>114,318</td>
<td>85,432</td>
</tr>
</tbody>
</table>
## Community Services and Supports (CSS) Component Worksheet

### Fiscal Year 2017/18

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FSP Programs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Family Stability FSP</td>
<td>1,202,577</td>
<td>457,911</td>
<td>623,907</td>
<td>0</td>
<td>120,759</td>
<td>0</td>
</tr>
<tr>
<td>2. Dual Diagnosis FSP</td>
<td>1,289,327</td>
<td>406,450</td>
<td>507,228</td>
<td>0</td>
<td>375,649</td>
<td>0</td>
</tr>
<tr>
<td>3. Juvenile Justice FSP</td>
<td>1,186,597</td>
<td>830,477</td>
<td>280,541</td>
<td>0</td>
<td>75,579</td>
<td>0</td>
</tr>
<tr>
<td>4. Transition Age Youth FSP</td>
<td>815,780</td>
<td>346,114</td>
<td>469,666</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5. Adult SMI FSP</td>
<td>5,203,813</td>
<td>2,580,646</td>
<td>1,939,120</td>
<td>590,047</td>
<td>0</td>
<td>94,000</td>
</tr>
<tr>
<td>6. Older Adult FSP</td>
<td>1,177,246</td>
<td>1,024,665</td>
<td>352,581</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Non-FSP Programs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Access Regional Services</td>
<td>11,767,488</td>
<td>2,727,169</td>
<td>3,680,637</td>
<td>5,163,864</td>
<td>195,818</td>
<td>0</td>
</tr>
<tr>
<td>8. Early Childhood Intervention</td>
<td>2,768,829</td>
<td>282,382</td>
<td>1,476,289</td>
<td>0</td>
<td>1,010,158</td>
<td>0</td>
</tr>
<tr>
<td>9. Transition Age Youth</td>
<td>849,078</td>
<td>65,941</td>
<td>783,137</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10. Supported Services to SMI</td>
<td>647,268</td>
<td>604,669</td>
<td>42,599</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>11. Dual Diagnosis</td>
<td>1,021,820</td>
<td>410,744</td>
<td>504,210</td>
<td>0</td>
<td>86,866</td>
<td>20,000</td>
</tr>
<tr>
<td>12. Family Stability</td>
<td>1,462,848</td>
<td>219,383</td>
<td>620,919</td>
<td>0</td>
<td>622,546</td>
<td>0</td>
</tr>
<tr>
<td><strong>CSS Administration</strong></td>
<td>3,539,908</td>
<td>3,539,908</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CSS MHSA Housing Program Assigned Funds</strong></td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total CSS Program Estimated Expenditures</strong></td>
<td>33,132,579</td>
<td>13,496,459</td>
<td>11,280,834</td>
<td>5,753,911</td>
<td>2,487,375</td>
<td>114,000</td>
</tr>
<tr>
<td><strong>FSP Programs as Percent of Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Fiscal Year 2018/19

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FSP Programs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Family Stability FSP</td>
<td>1,202,577</td>
<td>$ 457,911</td>
<td>623,907</td>
<td>0</td>
<td>120,759</td>
<td>0</td>
</tr>
<tr>
<td>2. Dual Diagnosis FSP</td>
<td>1,289,327</td>
<td>$ 406,450</td>
<td>507,228</td>
<td>0</td>
<td>375,649</td>
<td>0</td>
</tr>
<tr>
<td>3. Juvenile Justice FSP</td>
<td>1,186,597</td>
<td>$ 830,477</td>
<td>280,541</td>
<td>0</td>
<td>75,579</td>
<td>0</td>
</tr>
<tr>
<td>4. Transition Age Youth FSP</td>
<td>815,780</td>
<td>$ 346,114</td>
<td>469,666</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5. Adult SMI FSP</td>
<td>5,203,813</td>
<td>$ 2,580,646</td>
<td>1,939,120</td>
<td>590,047</td>
<td>0</td>
<td>94,000</td>
</tr>
<tr>
<td>6. Older Adult FSP</td>
<td>1,177,246</td>
<td>$ 1,024,665</td>
<td>352,581</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Non-FSP Programs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Access Regional Services</td>
<td>11,767,488</td>
<td>$ 2,727,169</td>
<td>3,680,637</td>
<td>5,163,864</td>
<td>195,818</td>
<td>0</td>
</tr>
<tr>
<td>8. Early Childhood Intervention</td>
<td>2,768,829</td>
<td>$ 282,382</td>
<td>1,476,289</td>
<td>0</td>
<td>1,010,158</td>
<td>0</td>
</tr>
<tr>
<td>9. Transition Age Youth</td>
<td>849,078</td>
<td>$ 65,941</td>
<td>783,137</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10. Supported Services to SMI</td>
<td>647,268</td>
<td>$ 604,669</td>
<td>42,599</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>11. Dual Diagnosis</td>
<td>1,021,820</td>
<td>$ 410,744</td>
<td>504,210</td>
<td>0</td>
<td>86,866</td>
<td>20,000</td>
</tr>
<tr>
<td>12. Family Stability</td>
<td>1,462,848</td>
<td>$ 219,383</td>
<td>620,919</td>
<td>0</td>
<td>622,546</td>
<td>0</td>
</tr>
<tr>
<td><strong>CSS Administration</strong></td>
<td>3,539,908</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CSS MHSA Housing Program Assigned Funds</strong></td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total CSS Program Estimated Expenditures</strong></td>
<td>33,132,579</td>
<td>13,496,459</td>
<td>11,280,834</td>
<td>5,753,911</td>
<td>2,487,375</td>
<td>114,000</td>
</tr>
<tr>
<td><strong>FSP Programs as Percent of Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CSS COMPONENT WORKSHEETS
## Community Services and Supports (CSS) Component Worksheet

### Fiscal Year 2019/20

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Estimated Total Mental Health Expenditures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FSP Programs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Family Stability</td>
<td>1,202,577</td>
<td>457,911</td>
<td>623,907</td>
<td>0</td>
<td>120,759</td>
<td>0</td>
</tr>
<tr>
<td>2. Dual Diagnosis</td>
<td>1,289,327</td>
<td>406,450</td>
<td>507,228</td>
<td>0</td>
<td>375,649</td>
<td>0</td>
</tr>
<tr>
<td>3. Juvenile Justice</td>
<td>1,186,597</td>
<td>830,477</td>
<td>280,541</td>
<td>0</td>
<td>75,579</td>
<td>0</td>
</tr>
<tr>
<td>4. Transition Age Youth</td>
<td>815,780</td>
<td>346,114</td>
<td>469,666</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5. Adult SMI</td>
<td>5,203,813</td>
<td>2,580,646</td>
<td>1,939,120</td>
<td>590,047</td>
<td>0</td>
<td>94,000</td>
</tr>
<tr>
<td>6. Older Adult</td>
<td>1,377,246</td>
<td>1,024,665</td>
<td>352,581</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Non-FSP Programs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Access Regional Services</td>
<td>11,767,488</td>
<td>2,727,169</td>
<td>3,680,637</td>
<td>5,163,864</td>
<td>195,818</td>
<td>0</td>
</tr>
<tr>
<td>8. Early Childhood Intervention</td>
<td>2,768,829</td>
<td>282,382</td>
<td>1,476,289</td>
<td>0</td>
<td>1,010,158</td>
<td>0</td>
</tr>
<tr>
<td>9. Transition Age Youth</td>
<td>849,078</td>
<td>65,941</td>
<td>783,137</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10. Supported Services to SMI</td>
<td>647,268</td>
<td>604,669</td>
<td>42,599</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>11. Dual Diagnosis</td>
<td>1,021,820</td>
<td>410,744</td>
<td>504,210</td>
<td>0</td>
<td>86,866</td>
<td>20,000</td>
</tr>
<tr>
<td>6. Family Stability</td>
<td>1,462,848</td>
<td>219,383</td>
<td>620,919</td>
<td>0</td>
<td>622,546</td>
<td>0</td>
</tr>
<tr>
<td><strong>CSS Administration</strong></td>
<td>3,539,908</td>
<td>3,539,908</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CSS MHSA Housing Program Assigned Funds</strong></td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total CSS Program Estimated Expenditures</strong></td>
<td>33,132,579</td>
<td>13,496,459</td>
<td>11,280,834</td>
<td>5,753,911</td>
<td>2,487,375</td>
<td>114,000</td>
</tr>
<tr>
<td><strong>FSP Programs as Percent of Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>82.1%</td>
</tr>
</tbody>
</table>
**APPENDIX I: MHSA PROGRAM REVIEW & MHSA PROGRAM EVALUATION STRUCTURE**

**PROGRAM: EPICENTER/ VOICES**

Provider: On the Move dba The Epicenter
Program Narrative: Provides community outreach and education for underserved Transition Age Youth populations, linking to resources for education, employment, housing, health and wellness.
FY 16 Total Program Cost: $ 358,000
MHSA Contribution: $ 87,190 (24%)
Evaluation Score: 19

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>4</td>
<td>Increases access and linkage to treatment; improves timely access to services for underserved populations.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>Services were provided primarily in Salinas.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>4</td>
<td>62% of clients were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>1</td>
<td>Program was 100% supported by MHSA.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$ 191.20/client.</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>2</td>
<td>Improvement needed in outcome reporting. Contractor is meeting deliverables. Invoicing and providing back up documentation in timely manner has been an issue. Contractor is aware of issue and has moved to monthly invoicing per request.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>2</td>
<td>Grants from community foundations; social justice groups.</td>
</tr>
</tbody>
</table>

**PROGRAM: SOUTH COUNTY CLINIC (KING CITY)**

Provider: Kinship Center / Seneca
Program Narrative: Provides outpatient mental health services to children and families in South County.
FY 16 Total Program Cost: $ 431,718
MHSA Contribution: $ 193,470 (45%)
Evaluation Score: 24

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>3</td>
<td>Improves timely access to services for underserved populations.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>5</td>
<td>Services are provided in King City.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>5</td>
<td>90% of children served were Latino.</td>
</tr>
</tbody>
</table>

|
the Latino population? 1-5

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>3</td>
<td>Improves timely access to services for underserved populations.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>15% of clients from South County.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>3</td>
<td>54% of clients were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>3</td>
<td>In FY 16, leveraged 53% from Medi-Cal and First 5.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$3/minute</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>2</td>
<td>QI review identified audit concerns.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>3</td>
<td>Included in BH Strategic Plan.</td>
</tr>
</tbody>
</table>

PROGRAM: PAJARO VALLEY PREVENTION AND STUDENT ASSISTANCE

Provider: Pajaro Valley Prevention and Student Assistance, Inc.
Program Narrative: Provides evidence-based mental health services to school age children in North Monterey County. Services provided in Spanish, Mixteco and other indigenous languages.
FY 16 Total Program Cost: $ 286,000
MHSA Contribution: $ 189,716 (66%)
### PROGRAM: SCHOOL BASED COUNSELING

Provider: Harmony at Home  
Program Narrative: School based counseling program for children exposed to violence and trauma.  
FY 16 Total Program Cost: $790,077  
MHSA Contribution: $91,120 (12%)  
Evaluation Score: 20

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>4</td>
<td>Increases access and linkage to treatment; improves timely access to services for underserved populations.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>100% of clients served reside in North County; only MHSA project in this area.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>5</td>
<td>95% of clients served were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>3</td>
<td>Billing Medi-Cal for nearly all clients; 34% of funds from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$1.45/minute $2,444/client</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>3</td>
<td>Exceeded contract goal.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>2</td>
<td>School District funds.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>4</td>
<td>Increases access and linkage to treatment; improves timely access to services for underserved populations.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>100% of clients are from Salinas.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>5</td>
<td>90% of clients were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>3</td>
<td>Program leverages 88% of funds from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>1</td>
<td>$231.86/client $2,010/client</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>3</td>
<td>Exceeded contract goal.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>1</td>
<td>Medi-Cal, School District/ LCAP funds.</td>
</tr>
</tbody>
</table>
PROGRAM: ARCHER CHILD ADVOCACY CENTER

Provider: MCBH
Program Narrative: Provides child-friendly central location for forensic interviews where there are allegations of child sexual abuse, with mental health therapist on-call and available for all interviews as needed.
FY 16 Total Program Cost: $ 8,858
MHSA Contribution: $ 5,581 (63%)
Evaluation Score: 18

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>3</td>
<td>Increases access and linkage to treatment.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>50% of clients are from Salinas, 11% of clients are from South County.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>4</td>
<td>67% of clients were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>1</td>
<td>75% of clients are Medi-Cal beneficiaries; 37% of funds are from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$3.52/minute $87/client</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>2</td>
<td>Excellent QI Review results.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>2</td>
<td>EPSDT for Medi-Cal eligible clients could be leveraged.</td>
</tr>
</tbody>
</table>

PROGRAM: D’ARRIGO CHILDREN’S CLINIC

Provider: Kinship Center
Program Narrative: Outpatient mental health services to children and families to support permancy for children, address the impact of adoption on a child and his/her family, and the impact on children being raised by a relative caregiver.
FY 16 Total Program Cost: $ 1,238,885
MHSA Contribution: $111,500 (9%)
Evaluation Score:

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>5</td>
<td>Provides individual and family counseling as authorized by Monterey County Behavioral Health.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>5</td>
<td>34% of clients from South County</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>4</td>
<td>68% of individuals served were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>3</td>
<td>92% of individuals served are Medi-Cal beneficiaries; 91% of total program cost is leveraged.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>Billed $842,157.68 for a total of 320,444 service minutes. Cost per minute of service</td>
</tr>
</tbody>
</table>
### PROGRAM: EARLY CHILDHOOD TREATMENT SERVICES

**Provider:** Kinship Center  
**Program Narrative:** Outpatient mental health services to children 0-5 (and their families) who are exhibiting early signs of attachment disruption, poor attunement with their caregivers, and exhibiting trauma symptoms and related behavioral dysregulation. Services will improve the early attachment relationship, resolve trauma experiences for children as well as the impact of trauma on a child and his/her family, and reduce mental health symptoms.  
**FY 16 Total Program Cost:** $171,193  
**MHSA Contribution:** $856.00 (0.005%)  
**Evaluation Score:** 18

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>5</td>
<td>Provides individual and family counseling as authorized by Monterey County Behavioral Health.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>5</td>
<td>34% of clients from South County</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>4</td>
<td>68% of individuals served were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>3</td>
<td>92% of individuals served are Medi-Cal beneficiaries; 99% of total program cost is leveraged.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>Billed $85,597.77 and had 32,290 service minutes. Cost per minute of service = $2.65</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>2</td>
<td>Utilize Avatar data entry. Could improve responsiveness to County Analysts Team requests.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>3</td>
<td>Part of BH strategic plan</td>
</tr>
</tbody>
</table>

### PROGRAM: PREVENTION AND RECOVERY IN EARLY PSYCHOSIS (PREP)

**Provider:** Family Service Agency of San Francisco dba Felton Institute  
**Program Narrative:** Provides evidence-based treatments designed for remission of early psychosis in TAY populations. PREP is an "Early Intervention Program" designed to promote recovery and related functional outcomes for a mental illness early in its emergence.  
**FY 16 Total Program Cost:** $500,000  
**MHSA Contribution:** $250,000 (50%)  
**Evaluation Score:** 18
<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>4</td>
<td>Increases access and linkage to treatment, improves timely access to services for underserved populations, and prevents involvement with the Juvenile Justice system.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>1</td>
<td>100% of the clients served reside on the Peninsula.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>4</td>
<td>72% of clients were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>3</td>
<td>82% of clients are Medi-Cal beneficiaries; leveraged 37% from Cal Grip Grant.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>1</td>
<td>$10.30/minute $1,420/client</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>1</td>
<td>Did not meet program goals.</td>
</tr>
</tbody>
</table>

PROGRAM: SEASIDE YOUTH DIVERSION PROGRAM

Provider: MCBH
Program Narrative: Provides group and family treatment to Seaside youth at risk of becoming involved in the juvenile justice system. Also coordinates community resources to promote health family environments and reduce recidivism in criminal activity.
FY 16 Total Program Cost: $ 25,576
MHSA Contribution: $ 16,288 (63%)
Evaluation Score: 16
PROGRAM: SILVER STAR RESOURCE CENTER

Provider: MCBH
Program Narrative: Provides mental health services to youth and TAY at risk of involvement with the juvenile justice system.
FY 16 Total Program Cost: $ 106,589
MHSA Contribution: $ 35,460 (33%)
Evaluation Score: 22

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>4</td>
<td>Increases access and linkage to treatment and improves timely access to services for underserved populations.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>81% of clients are from Salinas; 11% of clients are from North County; 5% of clients are from South County.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>5</td>
<td>86% of clients were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>2</td>
<td>90% of clients are Medi-Cal beneficiaries; 67% of funds are from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$2.27/minute $2,880/client</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>3</td>
<td>Met annual goals.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>2</td>
<td>Grants</td>
</tr>
</tbody>
</table>

PROGRAM: CHILD ADVOCATE PROGRAM

Provider: Probation Department
Program Narrative: Assesses and provides referrals to treatment and educational service to families with children age 5 and under in which one or both parents are under the supervision of the Probation Department who have been exposed to violence, toxic stress or involvement with criminal justice.
FY 16 Total Program Cost: $ 144,291
MHSA Contribution: $ 63,671 (44%)
Evaluation Score: 15

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>1</td>
<td>Not a mental health (MH) program.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>60% of the families that participate live in East Salinas, North Salinas, and Greenfield.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>5</td>
<td>87% of clients were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>2</td>
<td>Program leverages 55% of funds from other sources.</td>
</tr>
</tbody>
</table>
Is this program cost effective? 1-3 2 $473/client.

What is the level of contract performance? 1-3 1 Not a MH program.

Could this be funded by other sources? 1-3 1 MHSA funds cover the costs of a Probation Officer. Other sources should be leveraged for this non-MH service.

PROGRAM: SENIOR COMPANION PROGRAM

Provider: Seniors Council of Santa Cruz & San Benito Counties

Program Narrative: Recruits, trains and places Senior Companions to work with homebound clients living alone, and/or with chronic disabilities and/or whose caregiver needs respite from their responsibilities, and/or with mental health issues.

FY 16 Total Program Cost: $ 220,900

MHSA Contribution: $ 21,898 (10%)

Evaluation Score: 24

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>4</td>
<td>Provides access and linkage to treatment and improves timely access to appropriate services for underserved populations.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>5</td>
<td>100% of clients are from South County.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>5</td>
<td>100% of clients were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>3</td>
<td>Leveraging 90% from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>Annual contract amount is 10% of total program cost; provided services to 9 clients and includes location and training of volunteers $24,544/client.</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>2</td>
<td>Effective services in rural area to improve quality of life for clients.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>2</td>
<td>County General Fund, Area Agency on Aging, grants.</td>
</tr>
</tbody>
</table>

PROGRAM: PEER COUNSELING / FORTALECIENDO EL BIENESTAR

Provider: Alliance on Aging

Program Narrative: Provides intervention and support services to older adults suffering from depression, anxiety, grief, loss and other stressors that can occur later in life. Services are provided through trained and supervised Peer Counselors in the short and long-term.

FY 16 Total Program Cost: $ 239,823

MHSA Contribution: $ 239,823 (100%)

Evaluation Score: 20

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>4</td>
<td>Provides access and linkage to treatment and improves timely access to appropriate services for underserved populations.</td>
</tr>
<tr>
<td>Evaluation Question</td>
<td>Rating</td>
<td>Justification</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>--------</td>
<td>---------------</td>
</tr>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>3</td>
<td>Reduces stigma and discrimination.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>SOS focuses in Salinas but provides presentations throughout the County.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>1</td>
<td>Not leveraging funds from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>Cost per client/year not applicable. This program funds a position to coordinate the program; it is the only program providing opportunity for consumers to share their story of hope and recovery through these presentations in the County.</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>2</td>
<td>Program does not collect demographic data.</td>
</tr>
</tbody>
</table>

**PROGRAM: SUCCESS OVER STIGMA (SOS)**

Provider: Interim Inc.

Program Narrative: Consumer advocacy and outreach program to promote consumer involvement in planning and executing mental health services and anti-stigma messaging in the community.

FY 16 Total Program Cost: $100,261

MHSA Contribution: $100,261 (100%)

Evaluation Score: 15

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>3</td>
<td>Reduces stigma and discrimination.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>SOS focuses in Salinas but provides presentations throughout the County.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>1</td>
<td>Not leveraging funds from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>Cost per client/year not applicable. This program funds a position to coordinate the program; it is the only program providing opportunity for consumers to share their story of hope and recovery through these presentations in the County.</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>2</td>
<td>Program does not collect demographic data.</td>
</tr>
</tbody>
</table>
Could this be funded by other sources? 1-3 2  Grants.

PROGRAM: NAMI SELF-HELP SUPPORT & ADVOCACY

Provider: National Alliance on Mental Illness (NAMI) Monterey County
Program Narrative: Supports and advocates on behalf of consumers, families and friends of people with severe mental illness by providing outreach, education and support service contacts with individuals, families and caregivers in distress.
FY 16 Total Program Cost: $166,490
MHSA Contribution: $166,490 (100%)
Evaluation Score: 18

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>4</td>
<td>Increases access and linkage to treatment; improves timely access to appropriate services for underserved populations, and reducing stigma and discrimination</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>2</td>
<td>67% of clients are from Salinas and the Peninsula.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>3</td>
<td>53% of clients were Latino</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>1</td>
<td>Did not leverage funds from other sources in FY 16.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$1,513.50/participant</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>3</td>
<td>Reports are submitted on a timely basis.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>2</td>
<td>Grants.</td>
</tr>
</tbody>
</table>

PROGRAM: FAMILY SUPPORT GROUPS

Provider: MCBH
Program Narrative: Facilitates regional family support group meetings.
FY 16 Total Program Cost: $112,153
MHSA Contribution: $112,153 (100%)
Evaluation Score: 17

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>5</td>
<td>Increases access and linkage to treatment, improves timely access to appropriate services for underserved populations, and reduces stigma and discrimination</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>2</td>
<td>Support Groups provided in Marina and Salinas in FY 16.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>2</td>
<td>Data not available in FY 16.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>1</td>
<td>County Staff are providing these services after-hours. This is a value added to the community and an essential function of the community.</td>
</tr>
</tbody>
</table>
MHSA to provide family support and to obtain family input.

Is this program cost effective? 1-3  3  $1,602/client

What is the level of contract performance? 1-3  1  Reports are submitted via Avatar.

Could this be funded by other sources? 1-3  3  Included in BH Strategic Plan; Family support groups need to be expanded in facilities throughout the County.

PROGRAM: PEER SUPPORT & PEER PARTNERS FOR HEALTH

Provider: Interim Inc.
Program Narrative: Provides system or wellness navigators stationed at adult services clinics and other locations to welcome and guide clients through available services.
FY 16 Total Program Cost: $ 206,422
MHSA Contribution: $ 206,422 (100%)
Evaluation Score: 16

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>4</td>
<td>Increases access and linkage to treatment and reduces stigma and discrimination.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>Services are located in Salinas, the Peninsula, and North County.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>2</td>
<td>39% of clients were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>1</td>
<td>Not leveraging funds from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td></td>
<td>These staff have the potential capability of billing for services in the future and/or providing non-billable services that other clinicians would otherwise have to provide. This program utilizes peers and family members to engage with clients, providing them experience and assisting the clinical team to keep the client engaged in services, especially post-crisis, hospitalization, etc. $4,047/client.</td>
</tr>
</tbody>
</table>

What is the level of contract performance? 1-3  3  Reports are submitted on a timely basis.

Could this be funded by other sources? 1-3  3  Increasing Peer Support to the people we serve is one of the key directives of the MHSA.

PROGRAM: OMNI - RESOURCE CENTER - ADULTS

Provider: Interim Inc.
Program Narrative: Peer and family member operated mental wellness community center providing self-help, socialization and peer-support groups to address issues of personal growth and recovery.
FY 16 Total Program Cost: $502,963
MHSA Contribution: $502,963 (100%)

Evaluation Score: 16

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>4</td>
<td>Increases access and linkage to treatment and reduces stigma and discrimination.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>2</td>
<td>Services located in Salinas</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>2</td>
<td>27% of clients were Latino</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>1</td>
<td>Not leveraging funds from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>1</td>
<td>$797/client</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>3</td>
<td>This center provides a unique service in the community linking mental health consumers, homeless individuals and transitional age youth to essential needed services and create a community of hope and resilience.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>3</td>
<td>This program does not provide billable services and programming was initially developed by a consumer workgroup in collaboration with the County.</td>
</tr>
</tbody>
</table>

PROGRAM: CHINATOWN COMMUNITY LEARNING CENTER - CSUMB COLLABORATIVE

Provider: Interim Inc.
Program Narrative: Offers training experience for CSUMB MSW candidates in supporting homeless and other marginalized populations in Salinas.
FY 16 Total Program Cost: $137,510
MHSA Contribution: $137,510 (100%)

Evaluation Score: 15

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>3</td>
<td>Increases access and linkage to treatment and improves timely access to appropriate services for underserved populations.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>Services located in Chinatown, Salinas.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>2</td>
<td>FY 16 data not available.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>1</td>
<td>Not leveraging funding from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>2</td>
<td>$308.04/client</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>3</td>
<td>Reports are submitted on a timely basis.</td>
</tr>
</tbody>
</table>
**PROGRAM: MULTI-LINGUAL PARENT EDUCATION PARTNERSHIP**

Provider: Community Human Services  
Program Narrative: Provides parenting education training in English and Spanish to increase parenting confidence, knowledge and skills, and become more aware of available mental health services.  
FY 16 Total Program Cost: $179,387  
MHSA Contribution: $165,360 (92%)  
Evaluation Score: 18

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>4</td>
<td>Improves timely access to appropriate services for underserved populations and uses non stigmatizing strategies.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>2</td>
<td>Services are focused in Salinas; no services are provided in North or South County.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>5</td>
<td>About 86% of clients were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>1</td>
<td>Leveraging 8% from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>2</td>
<td>$151/client</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>2</td>
<td>Exceeding contract goals regarding services amount but limited data regarding effectiveness.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>2</td>
<td>Might qualify for grants from schools and community foundations.</td>
</tr>
</tbody>
</table>

**PROGRAM: SUICIDE PREVENTION**

Provider: Family Service Agency of the Central Coast  
Program Narrative: Provides outreach and education presentations to gatekeeper groups and the communities they service, to mitigate suicidal behavior and its negative consequences. This includes a 24/7/365 crisis line.  
FY 16 Total Program Cost: $300,500  
MHSA Contribution: $224,372 (75%)  
Evaluation Score: 19

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>3</td>
<td>Reduces stigma and discrimination.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>6% of clients from South County; 6% No. County &amp; 62% Salinas.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>4</td>
<td>62% of clients were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>1</td>
<td>Leveraging 25% from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$38.49/presentation/ participant/call</td>
</tr>
</tbody>
</table>
### PROGRAM: PROMOTORES MENTAL HEALTH PROGRAM

**Provider:** Central Coast Citizenship Project  
**Program Narrative:** Provides outreach and education campaigns to Latino populations for reducing stigma and promoting accessibility of mental health services.  
**FY 16 Total Program Cost:** $85,160  
**MHSA Contribution:** $85,160 (100%)  
**Evaluation Score:** 21

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>4</td>
<td>Increases access and linkage to treatment, improves timely access to appropriate services for underserved populations, and reduces stigma and discrimination.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>4</td>
<td>FY 16 demographic data shows 60% Salinas, 32% South County (average across 4 quarters).</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>4</td>
<td>76% of the clients were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>1</td>
<td>The Promotores Mental Health Program is funded with MHSA.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$20.42/client</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>3</td>
<td>Provides effective service to our underserved Latinos in an innovative way; reports are complete and timely.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>2</td>
<td>Might qualify for grants from public health and community foundations.</td>
</tr>
</tbody>
</table>

### PROGRAM: LATINO COMMUNITY PARTNERSHIP

**Provider:** Center for Community Advocacy  
**Program Narrative:** Promotes mental health awareness to Latino populations, particularly farmworkers, with the goal of providing education and training to community leaders and generating referrals to County Behavioral Health services.  
**FY 16 Total Program Cost:** $95,000  
**MHSA Contribution:** $95,000 (100%)  
**Evaluation Score:** 21

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>4</td>
<td>Increases access and linkage to treatment, improves timely access to appropriate services for underserved populations, and reduces stigma and discrimination.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>CCA focuses in Salinas and provides some</td>
</tr>
<tr>
<td>Evaluation Question</td>
<td>Rating</td>
<td>Justification</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>--------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>4</td>
<td>Improves timely access to appropriate services for underserved populations, and reduces stigma and discrimination.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>1</td>
<td>Services located on the Peninsula only.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>2</td>
<td>Program focuses on the African American Community but 29% of clients were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>1</td>
<td>Did not leverage funds from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>1</td>
<td>$5,611/client</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>2</td>
<td>Numbers of clients served meets goals, but amount of service provided to each client is low.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>1</td>
<td>Agency is highly regarded by local community and may be able to obtain funds from schools, faith-based community, local government, etc.</td>
</tr>
</tbody>
</table>

**PROGRAM: COMMUNITY PARTNERSHIP - LGBTQ COUNSELING**

Provider: Community Human Services
Program Narrative: Outreach, engagement and specialized outpatient mental health counseling for GLBTQ individuals and their significant others.
FY 16 Total Program Cost: $ 66,570
MHSA Contribution: $ 42,588 (64%)
### PROGRAM: 2- 1- 1 TELEPHONE REFERRAL SYSTEM

**Provider:** United Way of Monterey County  
**Program Narrative:** Phone and digital communications network to quickly and efficiently connect people to the social and health services they seek.  
**FY 16 Total Program Cost:** $269,000  
**MHSA Contribution:** $26,000 (10%)  
**Evaluation Score:** 20

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>4</td>
<td>Increases access and linkage to treatment and reduces stigma and discrimination.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>Serves all parts of the County.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>3</td>
<td>55% of callers were Latino; 31% of callers were Spanish Speaking.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>3</td>
<td>Leveraged 90% from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$26K annual contribution to service equals $1.66 per call.</td>
</tr>
</tbody>
</table>
| What is the level of contract performance? 1-3 | 3 | Reports are submitted on
Could this be funded by other sources? 1-3  1  Grants and other local government agencies, who use the website as a Resource Guide.

PROGRAM: VETERANS REINTEGRATION TRANSITION PROGRAM

Provider: Monterey County Office of Military & Veteran's Affairs
Program Narrative: Seeks out veterans in need of mental health, healthcare and social services, providing them with assistance and referrals. Also provides education and awareness to veterans, their dependents and survivors on entitled benefits.
FY 16 Total Program Cost: $ 20,000
MHSA Contribution: $ 20,000 (100%)
Evaluation Score: 13

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate?</td>
<td>3</td>
<td>Increases access and linkage to treatment.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity?</td>
<td>2</td>
<td>Majority of the clients are from Salinas and the Peninsula.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population?</td>
<td>2</td>
<td>27% of clients in Q1 FY 16 were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)?</td>
<td>1</td>
<td>Not leveraging funds from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective?</td>
<td>3</td>
<td>$23.06/client</td>
</tr>
<tr>
<td>What is the level of contract performance?</td>
<td>1</td>
<td>Not responsive and reports are not submitted on a timely basis.</td>
</tr>
<tr>
<td>Could this be funded by other sources?</td>
<td>1</td>
<td>Local community foundation Grants, Veterans Administration, and/or County General Fund.</td>
</tr>
</tbody>
</table>

PROGRAM: FAMILY REUNIFICATION PARTNERSHIP

Provider: MCBH
Program Narrative: Education, support and resource services for parents, to change and improve their capacity to provide for the needs and safety of their children.
FY 16 Total Program Cost: $ 513,921
MHSA Contribution: $ 246,682 (48%)
Evaluation Score: 23

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate?</td>
<td>5</td>
<td>Provides &quot;FSP&quot; services to children &amp; families involved in the Child Welfare system. These children have experienced severe abuse/neglect and have significant mental health needs.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity?</td>
<td>3</td>
<td>No. County (11%) &amp; Salinas (60%); So. County 11%</td>
</tr>
<tr>
<td>Evaluation Question</td>
<td>Rating</td>
<td>Justification</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------</td>
<td>---------------</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>4</td>
<td>64% of children served were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>3</td>
<td>100% of children served are Medi-Cal beneficiaries; 52% of funds are from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>2</td>
<td>$4.77/minute $11,420/client</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>3</td>
<td>QI Reviews overall good.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>3</td>
<td>Included in BH Strategic Plan.</td>
</tr>
</tbody>
</table>

**PROGRAM: TAY AVANZA**

Provider: MCBH

Program Narrative: Provides Transition Age Youth (“TAY”) with case management, therapy, groups and opportunities for positive social interactions.

FY 16 Total Program Cost: $ 1,710,106

MHSA Contribution: $ 530,909 (31%)

Evaluation Score: 23

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>4</td>
<td>Provides intensive mental health services to youth ages 16 to 25 and their families; many of the youth have a co-occurring substance abuse disorder; they are at risk of hospitalization, jail, lack of educational attainment, unemployment.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>5</td>
<td>North County 9% &amp; Salinas 44%; South County: 32%. Staff are also located in South County.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>4</td>
<td>70% of youth served were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>3</td>
<td>83% of youth served are Medi-Cal beneficiaries; 69% of funds are from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>2</td>
<td>$3.46/minute $7,534/client</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>2</td>
<td>Improvement needed in outcome reporting. Program productivity is below agency standards. Mgr and Sup aware of and working on productivity and timley documentation.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>3</td>
<td>Services to safety net population. MHSA funds are needed for clients who are not documented and to support non Medi-Cal billable supports and services.</td>
</tr>
</tbody>
</table>
PROGRAM: INTEGRATED CO-OCCURRING TREATMENT "ICT"

Provider: Door to Hope
Program Narrative: Provides services to adolescents and young adults with substance use and mental health disorders in a strengths-based and home visitation model.
FY 16 Total Program Cost: $ 785,321
MHSA Contribution: $ 392,661 (50%)
Evaluation Score: 25

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>5</td>
<td>Provides FSP services to youth ages 12-24 with a co-occurring mental illness and substance use disorder; these youth are at risk for out of home placement, involvement with the juvenile justice system, hospitalization, etc.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>FSP: South County (22%) &amp; Salinas (75%) SD: South County (13%) &amp; Salinas (64%)</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>5</td>
<td>FSP: 88% of youth served were Latino; SD: 86% of youth served were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>3</td>
<td>FSP: 68% are Medi-Cal beneficiaries; SD 76% are Medi-Cal beneficiaries.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$2.72/minute $8,013/client</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>3</td>
<td>Met contract goals.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>3</td>
<td>Included in BH Strategic Plan.</td>
</tr>
</tbody>
</table>

PROGRAM: JUVENILE MENTAL HEALTH COURT

Provider: MCBH
Program Narrative: Assesses and treats severely mentally ill youth with co-occurring disorders who are involved with the juvenile justice system.
FY 16 Total Program Cost: $ 489,869
MHSA Contribution: $ 316,927 (65%)
Evaluation Score: 23

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>5</td>
<td>Provides FSP services to youth with serious emotional disturbance and their families; they are either underserved or unserved; and they are involved in the juvenile justice system.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>FSP: North County (5%) &amp; Salinas (68%) = 73%. SD: 25% South County; 50% Salinas.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>5</td>
<td>FSP: 68% of youth served were Latino; SD: 100% were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources</td>
<td>3</td>
<td>FSP: 86% of youth served are Medi-Cal</td>
</tr>
</tbody>
</table>
### PROGRAM: SANTA LUCIA RESIDENTIAL PROGRAM FOR ADOLESCENT FEMALES

**Provider:** Door to Hope  
**Program Narrative:** Provides mental health services to adolescent females requiring residential care and who are placed in out-of-home services by Social Services or Probation.  
**FY 16 Total Program Cost:** $523,676  
**MHSA Contribution:** $256,601 (49%)  
**Evaluation Score:** 22

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>3</td>
<td>Provides residential treatment services for adolescent females with co-occurring mental illness and substance use disorders.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>North County (6%) &amp; Salinas (75%)</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>5</td>
<td>81% of individuals served were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>3</td>
<td>100% of children served are Medi-Cal beneficiaries; 51% of funds are from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$2.54/minute $32,730/client</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>2</td>
<td>Met contract goals. QI audits yielded program service documentation concerns. Program is addressing concerns.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>3</td>
<td>Explore potential for Drug Medi-Cal funding for this program.</td>
</tr>
</tbody>
</table>

### PROGRAM: PEACOCK ACRES, SUPPORTIVE HOUSING “INCARCERATION TO SUCCESS (I2S)”

**Provider:** Peacock Acres, Inc.  
**Program Narrative:** Provides transitional housing with independent living coaching for male youth who are involved with the juvenile justice and mental health systems.  
**FY 16 Total Program Cost:** $382,812  
**MHSA Contribution:** $268,484 (70%)  
**Evaluation Score:** 22

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>5</td>
<td>Provides supportive housing and mental health FSP services to male youth ages 16-25 who are on Probation or involved in the juvenile justice and mental health systems;</td>
</tr>
</tbody>
</table>
they are separated from their families; they are at risk of re-offending and are either underserved or unserved.

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>North County (14%) &amp; Salinas (71%)</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>5</td>
<td>86% of youth served were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>3</td>
<td>100% of youth served are Medi-Cal beneficiaries; 30% of funds are from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>2</td>
<td>$5.72/minute (includes housing costs.)</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>2</td>
<td>QI program reviews yielded some audit concerns.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>2</td>
<td>Included in BH Strategic Plan.</td>
</tr>
</tbody>
</table>

**PROGRAM: ADOPTION PRESERVATION**

Provider: Kinship Center / Seneca
Program Narrative: Specialty clinic to provide mental health “FSP” services to pre and post-adoptive families.
FY 16 Total Program Cost: $ 322,299
MHSA Contribution: $ 30,197 (9%)
Evaluation Score: 23

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>5</td>
<td>Provides mental health &quot;FSP&quot; services to pre and post adoption families who are caring for children ages 0-17; these children are in the Foster Care system and at risk of homelessness, juvenile delinquency, lack of educational attainment.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>4</td>
<td>South County (33%), Salinas (42%) &amp; No. County (11%)</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>4</td>
<td>100% of children served were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>3</td>
<td>100% of children served are Medi-Cal beneficiaries; 91% of program revenues are other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$17,644.74/client</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>2</td>
<td>Moderate.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>2</td>
<td>Included in BH Strategic Plan.</td>
</tr>
</tbody>
</table>

**PROGRAM: EARLY CHILDHOOD, SECURE FAMILIES/FAMILIAS SEGURAS**

Provider: MCBH
Program Narrative: County run program to provide mental health services to children ages 0-5 and
parents.
FY 16 Total Program Cost: $ 576,493
MHSA Contribution: $ 276,717 (48%)
Evaluation Score: 23

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>3</td>
<td>Provides evidence based mental health services to children age 0-5 and their parents/caregivers throughout Monterey County, focusing on underserved populations.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>5</td>
<td>South County 30%; Salinas 44%; North County 5%. 2 FTE's located in South County.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>5</td>
<td>83% of children served were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>2</td>
<td>83% of children served are Medi-Cal beneficiaries; 52% of total program cost is leveraged.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$2.53/minute $3,818/client</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>2</td>
<td>Improvement needed in outcome reporting. Program productivity is below agency standards. Mgr and Sup aware of and working on productivity and timley documentation. QI audit indicated strong assessments and few concerns.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>3</td>
<td>Part of BH Strategic Plan &amp; providing services to safety net population.</td>
</tr>
</tbody>
</table>

**PROGRAM: FAMILY PRESERVATION**

Provider: MCBH
Program Narrative: Intensive, short-term, in-home crisis intervention and family education program for monolingual Spanish families in Monterey County, designed to prevent out-of-home placement.
FY 16 Total Program Cost: $ 115,057
MHSA Contribution: $ 55,227 (36%)
Evaluation Score: 17

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>3</td>
<td>Provides intensive, short term family-based mental health treatment services provides in the home for children who are an eminent risk of being removed from their home.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>4</td>
<td>South County 100%; but only 1 client served in program.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>4</td>
<td>100% of children served were Latino, however, only 1 client served.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>3</td>
<td>100% of children served are Medi-Cal beneficiaries; 64% of funds are other sources.</td>
</tr>
<tr>
<td>Evaluation Question</td>
<td>Rating</td>
<td>Justification</td>
</tr>
<tr>
<td>------------------------------------------------------------</td>
<td>--------</td>
<td>---------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$18.68/minute</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>2</td>
<td>Only served 1 child and his/her family. Should be incorporated into other current service delivery programs.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>3</td>
<td>Services could be provided under other existing EPSDT Medi-Cal programs.</td>
</tr>
</tbody>
</table>

**PROGRAM: HOME PARTNERS**

Provider: MCBH


FY 16 Total Program Cost: $ 138,068

MHSA Contribution: $ 66,273 (48%)

Evaluation Score: 22

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>5</td>
<td>Provides intensive, short term, in-home crisis intervention and family education services for children and their families who require 24/7 therapist availability over a 4 to 6 weeks period. This is part of the Family Preservation Program.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>So. County (13%) &amp; Salinas (56%)</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>3</td>
<td>56% of children served were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>3</td>
<td>97% of children served are Medi-Cal beneficiaries.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$8,629/client</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>2</td>
<td>QI Program Reviews good. Program working to increased number of families served.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>3</td>
<td>Included in BH Strategic Plan.</td>
</tr>
</tbody>
</table>

**PROGRAM: NUEVA ESPERANZA**

Provider: Door to Hope

Program Narrative: Residential program for pregnant and parenting women with co-occurring disorders and their children, utilizing a range of comprehensive mental health and substance use disorder treatments, and parenting education services.

FY 16 Total Program Cost: $ 601,923

MHSA Contribution: $ 109,340 (18%)

Evaluation Score: 17

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>3</td>
<td>Provides residential recovery services for pregnant and parenting women with co-occurring mental illness and substance use disorders, and their young children.</td>
</tr>
</tbody>
</table>
Is this program part of addressing regional health inequity? 1-5

<table>
<thead>
<tr>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>North County (13%) &amp; Salinas (51%); Peninsula (30%)</td>
</tr>
</tbody>
</table>

Is this program part of increasing services to the Latino population? 1-5

<table>
<thead>
<tr>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>64% of individuals served were Latino.</td>
</tr>
</tbody>
</table>

Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3

<table>
<thead>
<tr>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>92% of individuals served are Medi-Cal beneficiaries; 82% of funds come from other sources.</td>
</tr>
</tbody>
</table>

Is this program cost effective? 1-3

<table>
<thead>
<tr>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$2.89/minute $12,807/client</td>
</tr>
</tbody>
</table>

What is the level of contract performance? 1-3

<table>
<thead>
<tr>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>QI reviews have yielded audit concerns related to billing and documentation of medical necessity to substantiate services. Contractor aware of concerns and has responded to plan of correction.</td>
</tr>
</tbody>
</table>

Could this be funded by other sources? 1-3

<table>
<thead>
<tr>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Explore potential for Drug Medi-Cal, i.e. Perinatal Substance Abuse treatment funding for this program.</td>
</tr>
</tbody>
</table>

PROGRAM: INTEGRATED CARE/ OLDER ADULT FSP

Provider: MCBH
Program Narrative: FSP services provided to older adults with severe mental illness with a co-occurring (physical and/or substance abuse) disorder.
FY 16 Total Program Cost: $131,966
MHSA Contribution: $131,196 (100%)
Evaluation Score: 19

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>5</td>
<td>Provides FSP services to older adults with severe mental illness with a co-occurring (physical and/or substance abuse) disorder who are at risk of: losing their community placement, hospitalization, institutionalization, and homelessness. They are either underserved or unserved.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>1</td>
<td>6% North County, 6% Salinas, and 6% South County; 69% Peninsula.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>1</td>
<td>94% of adults served were White.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>3</td>
<td>87% of adults served are Medi-Care; 13% are Medi-Cal beneficiaries.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$2.75/minute $8,247/client</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>3</td>
<td>The population of older adults with co-occurring specialty needs is rapidly expanding. The individuals served require the highest level of intensive services in order to maintain their lives in the community.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>3</td>
<td>This is a requirement of the MHSA to provide</td>
</tr>
</tbody>
</table>
a FSP level of service to individuals who would otherwise be homeless or in need of 24 hour care.

**PROGRAM: MENTAL HEALTH COURT, CREATING NEW CHOICES**

Provider: MCBH  
Program Narrative: Provides intensive case management, psychiatric care, Probation supervision and therapeutic mental health court services to mentally ill criminal offenders.  
FY 16 Total Program Cost: $ 759,020  
MHSA Contribution: $ 504,718 (66%)  
Evaluation Score: 23

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>5</td>
<td>Provides FSP level services including group therapy, medication management, individualized treatment planning, housing resources, life skills, transportation assistance, school and/or employment assistance, and 24/7 access to team member for crisis intervention and support. Population of focus: adults, age 18 and older with severe mental illness who are involved with the criminal justice system.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>Salinas &amp; No. County (74%)</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>3</td>
<td>35% of adults served were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>3</td>
<td>47% are adults served are Medi-Cal beneficiaries; 34% of funds are from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$3.27/minute (not inclusive of housing costs). $18,146/client.</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>3</td>
<td>Program has limitations: clients are relocated from other regions to Salinas region for housing and program groups; all justice partners must agree to accept clients into the program resulting in not all adults with serious mental illness are accepted into program.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>3</td>
<td>This program provides a high level of intensive mental health treatment to a specialty population who are at high risk for recidivism without this level of support.</td>
</tr>
</tbody>
</table>
PROGRAM: MCHOME

Provider: Interim Inc.
Program Narrative: FSP initiative providing outreach/engagement and wrap-around services for adults with psychiatric disabilities who are homeless or at-risk of homelessness.
FY 16 Total Program Cost: $903,360
MHSA Contribution: $542,192 (60%)
Evaluation Score: 21

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>5</td>
<td>Provides outreach/engagement and mental health FSP services to adults with severe mental illness who are homeless; they are either underserved or unserved. NOTE: supportive housing services are provided in a separate budget.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>8% No. County &amp; 51% Salinas; 37% Peninsula.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>2</td>
<td>22% of adults served were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>2</td>
<td>68% of adults served are Medi-Cal beneficiaries; 40% of funds are from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$7.46/minute (not inclusive of housing costs); Leveraging City Funds $12,375/client</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>3</td>
<td>This is one of the identified target populations that the MHSA is designed to serve beginning with a robust outreach and engagement effort to reach the homeless population.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>3</td>
<td>There is an increasing crisis with homelessness within Monterey County; this program only puts a dent in addressing the overwhelming need.</td>
</tr>
</tbody>
</table>

PROGRAM: LUPINE GARDENS

Provider: Interim Inc.
Program Narrative: FSP services provided to very-low income individuals with a serious mental health diagnosis, whom are homeless or at-risk of homelessness.
FY 16 Total Program Cost: $319,684
MHSA Contribution: $159,842 (50%)
Evaluation Score: 21

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>5</td>
<td>Lupine Gardens provides a FSP level of services to very-low income individuals with a serious mental health diagnosis, all of whom are homeless or at risk of homelessness.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>14% North County &amp; 82% Salinas.</td>
</tr>
</tbody>
</table>
**PROGRAM: SUNFLOWER GARDENS**

Provider: Interim Inc.
Program Narrative: Residential FSP services provided to very-low income individuals with a serious mental health diagnosis, all of whom are homeless or at-risk of homelessness.  
FY 16 Total Program Cost: $ 253,435  
MHSA Contribution: $ 126,718 (50%)  
Evaluation Score: 21

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>5</td>
<td>Sunflower Gardens provide a FSP level of services to very low-income individuals with a serious mental health diagnosis, all of whom are homeless or at risk of homelessness.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>6% North County &amp; 87% Salinas.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>2</td>
<td>32% were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>3</td>
<td>79% of individuals are Medi-Cal beneficiaries; 50% of funds are from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$2.93/minute</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>3</td>
<td>Reports are submitted on a timely basis.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>3</td>
<td>Funds from the state and federal government have increasingly been cut making it ever more difficult to create safe affordable housing for adults with mental illness disabilities.</td>
</tr>
</tbody>
</table>
PROGRAM: DRAKE HOUSE

Provider: Front St., Inc.
Program Narrative: Residential facility serving older adult individuals with co-occurring mental health and physical conditions who have been unserved or underserved in the community.
FY 16 Total Program Cost: $1,313,872
MHSA Contribution: $927,539 (70%)
Evaluation Score: 19

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>5</td>
<td>Provides FSP services including supportive housing to older adults with severe mental illness, often with a co-occurring (physical and/or substance abuse) disorder who are at risk of: hospitalization; institutionalization; and homelessness. They are either underserved or unserved. There are extremely limited options for providing this type of housing to disabled older adults with these types of issues.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>1</td>
<td>92% Peninsula. Located on the Peninsula but served all of Monterey County residents who need this level of service.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>1</td>
<td>72% of older adults served were White.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>3</td>
<td>77% of older adults served are Medi-Care; 18% are Medi-Cal beneficiaries; 30% of funds are from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$4.14/minute (inclusive of housing costs).</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>3</td>
<td>The population of older adults with co-occurring specialty needs is rapidly expanding. There are very few residential facilities that have the capacity to manage the range of specialty needs of older adults with serious mental illness.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>3</td>
<td>There is a dearth of funding sources that specifically provide for older adults with co-occurring mental health, primary care, substance use and cognitive disabilities.</td>
</tr>
</tbody>
</table>

PROGRAM: ROCKROSE GARDENS

Provider: Interim Inc.
Program Narrative: Provides community independent living for very-low income individuals with a serious
FY 16 Total Program Cost: $115,114
MHSA Contribution: $57,557 (50%)
Evaluation Score: 19
<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>5</td>
<td>Rockrose Gardens provides community independent living in a supportive housing program as well; serves very low-income individuals with a serious mental health diagnosis, all of whom are homeless or at risk of homelessness.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>2</td>
<td>5% North County and 90% Peninsula.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>1</td>
<td>14% were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>2</td>
<td>60% of individuals are Medi-Cal beneficiaries; 50% of funds are from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$2.93/minute $5,481/client</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>3</td>
<td>Documentation, billing and reports are submitted on a timely basis.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>3</td>
<td>Funds from the state and federal government have increasingly been cut making it ever more difficult to create safe affordable housing for adults with mental illness disabilities.</td>
</tr>
</tbody>
</table>

**PROGRAM: DUAL RECOVERY SERVICES**

Provider: Interim Inc.
Program Narrative: Provides outreach, outpatient treatment and aftercare services for adults with co-occurring disorders.
FY 16 Total Program Cost: $ 561,103
MHSA Contribution: $ 264,219 (47%)
Evaluation Score: 19

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>3</td>
<td>Provides outreach, outpatient mental health services and aftercare for adults with co-occurring serious mental illness and substance use disorders.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>4% No. County &amp; 50% Salinas; 12% South County.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>3</td>
<td>41% clients served were Latino; 38% were White.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>2</td>
<td>51% individual served are Medi-Cal beneficiaries; SAMHSA grant funds used for outreach &amp; aftercare services; 53% of funds are from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$2.91/minute for mental health services.</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-2</td>
<td>2</td>
<td>Moderate.</td>
</tr>
</tbody>
</table>
**PROGRAM: COMMUNITY PARTNERSHIP - HIV/AIDS**

Provider: Community Human Services  
Program Narrative: Outreach, engagement and specialized outpatient mental health counseling for individuals with HIV/AIDS and their significant others.  
FY 16 Total Program Cost: $2,649.01  
MHSA Contribution: $1,836.31 (69%)  
Evaluation Score: 10

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>2</td>
<td>Provides outreach, engagement and specialized outpatient mental health counseling (individual, family and group) for individuals with HIV/AIDS and their significant others. This population has been historically underserved in Monterey County and has significant mental health issues related to HIV/AIDS status.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>2</td>
<td>Services are provided in Salinas and Peninsula.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>1</td>
<td>55% of clients were Latino but small sample size of only 9 clients seen by the program total.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>1</td>
<td>61% of clients served were Medi-Cal beneficiaries.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>1</td>
<td>Contract total in FY 16 was $36,292; only $2,649.01 utilized. $294.33/client</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>1</td>
<td>Low number of total clients served.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>2</td>
<td>Clients could be referred to NMC’s NIDO clinic (where BHB provides psychiatric services) or CHOMP’s OPUS Clinic.</td>
</tr>
</tbody>
</table>

**PROGRAM: RETURN TO WORK BENEFITS COUNSELING**

Provider: Central Coast Center for Independent Living  
Program Narrative: Provides adults and youth with mental health disabilities with financial and medical benefits counseling, individual advocacy, housing assistance, and independent living skills and assistive technologies training.  
FY 16 Total Program Cost: $119,933  
MHSA Contribution: $119,933 (100%)  
Evaluation Score: 16

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>3</td>
<td>Provides financial, medical benefits counseling, individual advocacy, housing assistance, and independent living skills.</td>
</tr>
</tbody>
</table>
assistance, independent living skills training, assistive technology and benefits counseling to assist consumers to make an informed decision about employment and Social Security benefits.

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>Based in Salinas but will meet individuals near their home.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>4</td>
<td>60% of clients served were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>1</td>
<td>Receives grants and other funding to support staffing and equipment costs in unknown amounts</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>1</td>
<td>Data to be gathered.</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>3</td>
<td>Meeting contract goals for number of unduplicated clients served.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>1</td>
<td>Existing program is augmented with MHSA funds.</td>
</tr>
</tbody>
</table>

**PROGRAM: ACCESS: OUTPATIENT SERVICES**

Provider: Community Human Services
Program Narrative: Individual and family outpatient mental health counseling for people of all ages.
FY 16 Total Program Cost: $639,825
MHSA Contribution: $581,944 (84%)
Evaluation Score: 18

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>3</td>
<td>Provides individual and family counseling as authorized by Monterey County Behavioral Health.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>North County (12%) and Salinas (72%).</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>3</td>
<td>46% of individuals served were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>1</td>
<td>92% of individuals served are Medi-Cal beneficiaries; 16% of total program cost is leveraged.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$2.51/minute</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>2</td>
<td>Served 590 clients but not meeting funding amounts as per contract.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>3</td>
<td>Services are provided primarily to Medi-Cal beneficiaries.</td>
</tr>
</tbody>
</table>
**PROGRAM: JUVENILE SEX OFFENDER RESPONSE TEAM (JSORT)**

Provider: Probation Department & MCBH  
Program Narrative: Provides assessment and treatment services to youth who have sexually offended. Treatment services involve families of offenders.  
FY 16 Total Program Cost: $263,932  
MHSA Contribution: $172,500 (65%)  
Evaluation Score: 19

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>3</td>
<td>Provides assessment and treatment services to youth who have sexually offended. Treatment services involve families of offenders.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>3</td>
<td>41% of clients are from Salinas, 15% of clients are from North County, and 13% are from South County.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>4</td>
<td>63% of clients served were Latino.</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)? 1-3</td>
<td>1</td>
<td>Leveraging 35% from other sources.</td>
</tr>
<tr>
<td>Is this program cost effective? 1-3</td>
<td>3</td>
<td>$3.32/minute $5,738/client</td>
</tr>
<tr>
<td>What is the level of contract performance? 1-3</td>
<td>2</td>
<td>Partially reached program performance goals.</td>
</tr>
<tr>
<td>Could this be funded by other sources? 1-3</td>
<td>3</td>
<td>Included in BH Strategic Plan. Critical service for high risk population that could not be served without this program.</td>
</tr>
</tbody>
</table>

**PROGRAM: POSITIVE BEHAVIORAL INTERVENTION & SUPPORTS (PBIS)**

Provider: Monterey County Office of Education  
Program Narrative: School based program focused on reducing stigma towards mental health issues, reducing bullying and improving school climate to assist in reducing anxiety and depressive disorders.  
FY 16 Total Program Cost: $100,000  
MHSA Contribution: $50,000 (50%)  
Evaluation Score: 23

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Rating</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program part of the MHSA Mandate? 1-5</td>
<td>4</td>
<td>Program helps address disparities and engage underserved populations by involving all students at all levels of PBIS intervention to improve the overall general school climate.</td>
</tr>
<tr>
<td>Is this program part of addressing regional health inequity? 1-5</td>
<td>5</td>
<td>100% of students are from South County.</td>
</tr>
<tr>
<td>Is this program part of increasing services to the Latino population? 1-5</td>
<td>5</td>
<td>Estimated 80-100% students were Latino.</td>
</tr>
<tr>
<td>Question</td>
<td>Rating</td>
<td>Response</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Is this program leveraging other resources (maximizing community impact with MHSA dollars)?</td>
<td>2</td>
<td>Program leverages School Climate Transformation grant funding for 50% of total program cost.</td>
</tr>
<tr>
<td>Is this program cost effective?</td>
<td>3</td>
<td>$25.00/client</td>
</tr>
<tr>
<td>What is the level of contract performance?</td>
<td>2</td>
<td>Data reporting to County could be more timely; implementation efforts have exceeded expectations.</td>
</tr>
<tr>
<td>Could this be funded by other sources?</td>
<td>1</td>
<td>Increase the School Climate Transformation grant funding.</td>
</tr>
</tbody>
</table>

**MHSA PROGRAM EVALUATION STRUCTURE**

1. **IS THIS PROGRAM PART OF THE MHSA MANDATE?**

   Prevention and Early Intervention (PEI)
   5=One of the required PEI programs and implementing the three PEI strategies (see “Requirements” below).
   4=One of the required PEI programs and implementing two of the three PEI strategies.
   3=One of the required PEI programs and implementing one of the three PEI strategies.
   2= Not one of the required PEI programs and not implementing any of the three PEI strategies.
   1= Not a mental health program.

   Community Services and Supports (CSS)
   5= High Functioning Full Service Partnership (FSP), essential part of providing care to FSP priority populations, and applies the six guiding principles for system transformation.
   4= Moderately Functioning FSP, essential part of providing care to FSP priority populations, and applies at least four of the guiding principles for system transformation.
   3= Non-FSP, essential part of providing care to priority populations, and applies at least three of the guiding principles for system transformation.
   2= Non-FSP, essential part of providing care to priority populations, and applies less than three of the guiding principles for system transformation.
   1= Does not provide care to priority populations, and does not apply the guiding principles for system transformation.

2. **IS THIS PROGRAM PART OF ADDRESSING REGIONAL HEALTH INEQUITY?**

   5=South County
   4=>30% South County
   3=Salinas Valley & North County
   2=Salinas Valley & Peninsula
   1=Peninsula

   South Monterey County continues to be underserved. 20% of the Medi-Cal population lives in South Monterey County.
County. However, only 13% of individuals receiving therapeutic services from Monterey County Behavioral Health (MCBH) reside in South County. 7% of individuals served by Alcohol and Other Drug Prevention and Treatment services were from South County. Services provided by contracted providers follow the same trend (MCBH Strategic Plan, pg.7). Ratings are based on where funded programs serve clients and/or the residence of the clients served by the program. Regions of the County that have been prioritized to receive funding based on the MCBH Strategic Plan receive higher ratings.

2. IS THIS PROGRAM PART OF INCREASING SERVICES TO THE LATINO POPULATION?

5=80-100% of clients served were Latino
4=60-79% of clients served were Latino
3=40-59% of clients served were Latino
2=20-39% of clients served were Latino
1=0-19% of clients served were Latino

MCBH is committed to reducing health inequities by increasing services to the Latino Population. 78% of Medi-Cal eligible in Monterey County are Latino; however, only 32% of individuals served by the Adult System of Care are Latino (MCBH Strategic Plan, pg.7).

3. IS THIS PROGRAM LEVERAGING OTHER RESOURCES (MAXIMIZING COMMUNITY IMPACT WITH MHSA DOLLARS)?

3=Leveraging 71-100%
2=Leveraging 50-70%
1=Leveraging <50%

Rating: (High=3; Moderate =2; Low=1)

The rating for this evaluation question is determined by using “percent of funds leveraged,” which is assessed by calculating either the percent of total program costs that are paid for from sources other than MHSA or percent of program clients who are Medi-Cal beneficiaries. If data is available on both, the higher percentage of the two is used to assign the rating.

4. IS THIS PROGRAM COST EFFECTIVE?

Cost effectiveness is the degree to which a program is effective or productive in relation to its cost. For example, in 2015 dollars, CalMHSA’s annual investment costs in Applied Suicide Intervention Skills Training (ASIST) averaged just over $350,000. The RAND Corporation estimated that one year of CalMHSA’s investment in ASIST may help to avert 3,569 suicide attempts over the next 28 years, of which approximately 143 would have been fatal and 581 would have been otherwise incapacitating. (Analysis of the Benefits and Costs of CalMHSA’s Investment in Applied Suicide Intervention Skills Training by Ashwood, et al).

Rating: (High=3; Moderate =2; Low=1)

The rating for this evaluation question uses “average service value per year per client” or “cost per unit of service” data. Average service value per client and cost per unit of service are taken from the “FY 15-16 Data Driven Decisions (D3) Report”. If the cost per unit of service is not available in the D3 Report, then
it is calculated from the dollar amount paid in the contract and the program’s report of the number of clients served.

5. **WHAT IS THE LEVEL OF CONTRACT PERFORMANCE?**

Rating: (High=3; Moderate=2; Low=1)

The rating for “contract performance” is based on an assessment of the degree to which a program is meeting contract requirements and goals, for example service numbers, outcomes, timeliness of invoices/reports, responsiveness to contract manager requests for information.

6. **COULD THE PROGRAM BE FUNDED BY OTHER SOURCES?**

Rating: (No=3; Maybe=2; Yes=1)

The ratings for this evaluation question are based on an assessment of the degree to which a program could be funded by other sources, including the consideration of whether a program has explored, applied for, and received or been denied funding from other sources. For example, school based mental health programs could be funded, at least in part, with the Local Control Funding Formula (LCFF). The LCFF requires school districts to involve parents in planning and decision-making as well as in developing Local Control and Accountability Plans.

Additionally, if a program is highly aligned with the MHSA funding priorities and part of the MHSA’s mandate, the program automatically receives a rating of ‘3’ to reflect the responsibility of MCBH to provide mental health services.

**Requirements per the MHSA & PEI Regulations ("The MHSA Mandate")**

A. **Required PEI Strategies:**
   (1) Be designed and implemented to help create access and linkage to treatment to children, youth, adults, and seniors with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to care provided by county mental health programs.
   (2) Be designed, implemented, and promoted in ways that improve timely access to appropriate services for underserved populations through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services.
   (3) Be designed, implemented, and promoted using strategies that are non-stigmatizing and non-discriminatory.

B. **Required PEI Programs:**
   (1) “Access and Linkage to Treatment Program” means connecting children, youth, adults, and seniors with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to care provided by county mental health programs.
   (2) “Early Intervention Program” means treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes that may result from untreated mental illness.
   (3) “Outreach for Increasing Recognition of Early signs of Mental Illness Program” is a process of engaging,
encouraging, educating, and/or training, and learning from potential responders about ways to recognize and respond effectively to early signs or potentially severe and disabling mental illness.

(4) “Prevention Program” means set of related activities to reduce the risk of developing a potentially serious mental illness and to build protective factors and reduce risk factors.

(5) “Stigma and Discrimination Reduction Program” means the County’s direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families (PEI Regulations).

C. Required CSS Component Service Categories:
(1) Full Service Partnership (FSP). The County shall develop and operate programs to provide services under the Full Service Partnership Service Category. “Full Service Partnership” means the collaborative relationship between the County and the client, and when appropriate the client’s family, through which the County plans for and provides the full spectrum of community services so that the client can achieve the identified goals.

(2) General System Development. These funds are to be allocated to improve the county mental health service delivery system for all clients and their families and/or to pay for specified mental health services and supports for clients, and/or when appropriate their families. Also referred to as System Development or SD.

(3) Outreach and Engagement. The County shall conduct outreach to provide equal opportunities for peers who share the diverse racial/ethnic, cultural, and linguistic characteristics of the individuals/clients served. Outreach and Engagement funds may be used to pay for: (1) Strategies to reduce ethnic/racial disparities. (2) Food, clothing, and shelter, but only when the purpose is to engage unserved individuals, and when appropriate their families, in the mental health system. (3) Outreach to entities such as community based organizations, schools, and other sectors.

D. Priority Populations in the MHSA and Required Eligibility Criteria for the Full Service Partnership (FSP) Service Category:
Clients with severe mental illness who are underserved or unserved and at risk of one of the following:
(1) Homelessness or at risk of being homeless.
(2) Institutionalization.
(3) Nursing home or out-of-home care.
(4) Frequent users of hospital and/or emergency room services as the primary resource for mental health treatment.
(5) Involvement in the criminal justice system or foster care system.


**DEFINITIONS PER THE MHSA & PEI REGULATIONS**

Community Program Planning Process means the process to be used by the County to develop Three-Year Program and Expenditure Plans, and Annual Updates in partnership with stakeholders to:
(1) Identify community issues related to mental illness resulting from lack of community services and supports, including any issues identified during the implementation of the Mental Health Services Act;
(2) Analyze the mental health needs in the community; and,
(3) Identify and re-evaluate priorities and strategies to meet those mental health needs.

Stakeholders means individuals or entities with an interest in mental health services in the State of California, including but not limited to: individuals with serious mental illness and/or serious emotional disturbance and/or their families; providers of mental health and/or related services such as physical health care and/or social services; educators and/or representatives of education; representatives of law enforcement; and any other organization that represents the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families.

Underserved means clients of any age who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services, but are not provided the necessary or appropriate opportunities to support their recovery, wellness and/or resilience. When appropriate, it includes clients whose family members are not receiving sufficient services to support the client’s recovery, wellness and/or resilience. These clients include, but are not limited to, those who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, out-of-home placement or other serious consequences; members of ethnic/racial, cultural, and linguistic populations that do not have access to mental health programs due to barriers such as poor identification of their mental health needs, poor engagement and outreach, limited language access, and lack of culturally competent services; and those in rural areas, Native American rancherias and/or reservations who are not receiving sufficient services.

Unserved means those individuals who may have serious mental illness and/or serious emotional disturbance and are not receiving mental health services. Individuals who may have had only emergency or crisis-oriented contact with and/or services from the County may be considered unserved.

**Glossary of Acronyms/Abbreviations**

BH: Behavioral Health

FSP: Full Service Partnership

FY 16: Fiscal Year 2015-16 (July 1, 2015 through June 30, 2016)

MCBH: Monterey County Behavioral Health

MHSA: Mental Health Services Act

N/A: Not applicable or not available.

SD: System Development, also referred to as General System Development
APPENDIX II: CPP INTERVIEW GUIDE
COMMUNITY INPUT ABOUT MENTAL HEALTH SERVICES FOCUS

GROUP QUESTIONS

1. Have you used mental health services before?
2. What services and from which organization(s)?
3. What did you like about the services?
4. What needs to change or improve about the services? How can services improve?
5. Is the location (parking, public transportation, distance, etc.) of the agency where you received services convenient?
6. Are the services available during hours that are convenient for you? If not, when would be convenient?
7. What do you believe are the barriers to accessing County Behavioral Health Services?
8. What do you think are some solutions to these barriers?
9. What services or supports are needed in your neighborhood or community to improve your mental health?
APPENDIX III: UNDERSERVED COMMUNITIES (BY ZIP CODE) SURVEY

Monterey County Behavioral Health provides mental health and substance use services to the community. One of our goals is to serve more Latinos and Spanish speaking people. We need your advice on how and what could be improved — Thank you!

About you:

Age:  
- 15 and under  
- 16-25  
- 25-59  
- 60+

Language:  
- English  
- Spanish  
- Indigenous Language (Triqui, Mixteco, Zapoteco)

Ethnicity:  
- Hispanic/Latino  
- Other

Gender:  
- Male  
- Female

Zip Code Where you Live

If you had a mental health or alcohol/drug concern, where would you feel most comfortable receiving services?

- Mental Health Clinic  
- School  
- Church  
- Community Center  
- Primary Care Doctor  
- Home  
- Other

We are looking at ways to expand services; Rank your preference in order 1= first choice; 5=last choice:

- Appointment during the day (8AM-5PM)  
- Appointment on weekend  
- Appointment after work hours (5PM to 8:00 PM)  
- Appointment on your phone or computer  
- Other

What else do we need to know to better assist you, your family, or your community, in accessing mental health services and services to treat substance use problems?
APPENDIX IV: 30-DAY PUBLIC REVIEW AND COMMENT PERIOD

(Contents to be entered following completion of the 30-Day Public Review and Comment Period ending September 21, 2017.)
Monterey County Health Department
Behavioral Health Bureau

Cultural Competency Action Plan
June 15, 2017
Table of Contents

Introduction .......................................................................................................................... 333
   How to Use the Document and Road Map........................................................................ 334
   Connecting the Dots ......................................................................................................... 334

Population Groups Demographics and Snapshots ............................................................ 337

Overall Findings Across Focus Groups ............................................................................. 344
   Themes Across Groups .................................................................................................. 344
      Barriers ..................................................................................................................... 344
      Resiliency Factors .................................................................................................... 346
   Observations and Participant Recommendations/Solutions ........................................... 347
      Suggestions to Improve Access to County Mental Health Services ....................... 347
      What do MCBH staff/clinicians need to know about clients and their service needs? ...... 349

Population Specific Findings ............................................................................................. 350
   African American/ Black ............................................................................................... 350
   Asian American/Pacific Islander .................................................................................... 351
   Deaf and Hard of Hearing ............................................................................................ 352
   Farmworker/Spanish Speaking .................................................................................... 353
   Homeless/Displaced ..................................................................................................... 354
   LGBTQ ......................................................................................................................... 355
   System Impacted Families ............................................................................................ 356

Staff Specific Summary ..................................................................................................... 358

Recommendations ............................................................................................................. 359
   Priority 1: Improve Equity ........................................................................................... 359
   Priority 2: Strengthen Collaboration and Partnerships ................................................. 361
   Priority 3: Institutionalize Cultural Relevancy Practice/Perspective .............................. 363

Conclusion ....................................................................................................................... 365

Culturally Relevant Framework ........................................................................................ 367

Appendices ....................................................................................................................... 374

Questions to guide the development of the Action Plan: .................................................. 374
   ❖ How do clients self-identify? ..................................................................................... 374
   ❖ Experience using Monterey County Behavioral Health services? ............................ 374
   ❖ Barriers to accessing mental health services? ............................................................ 374
   ❖ Alternatives to mental health services or other forms of support? ............................ 374
   ❖ What types of mental health services need to be offered? ........................................ 374
Solutions/suggestions to improve access to mental health services? ........ 374

Sources of data: .......................................................................................................................... 374

Appendix 2: Training Standards ............................................................................................... 375
Appendix 3: CRHC Mission Statement ..................................................................................... 377
Appendix 4: Cultural Competency Requirements ..................................................................... 378
These eight criteria are a mechanism to examine where MHPs lie on the scale of cultural competence. Having used the criteria to form a logic model, the CCPR’s development and ......................................................................................... 378
Appendix 5: National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care ........................................................................................................... 379
Introduction

The development of the Monterey County Health Department Behavioral Health Bureau (MCHD BHB) Cultural Competency Action Plan (the Action Plan) is the next logical step after the annual revision of the Behavioral Health Cultural Competency Plan Requirements (BHB CCPR). MCHD BHB has elected to create an Action Plan that can be used to carry out the Cultural Competency Plan BHB CCPR Requirements by incorporating client/community input and adhering to mandates while guided by initiatives and plans.

To inform the Action Plan, the consultant team studied the CCPR and the Strategic Plan, consulted with stakeholders, and worked closely with MCHD BHD the Cultural Relevancy and Humility Committee (CRHC) workgroup. The Action Plan was developed with guidance and input from the following stakeholders: MCHD BHB employees, key community leaders, community advocates and activists, clients and CRHC.

In developing the Action Plan, we found no “new information” regarding service gaps and, in fact, our research substantiated what was already written in various plans, acts, initiatives, and documents that help to guide our plan. Throughout these documents, the overarching goal is to improve services to clients by making services culturally relevant and improving access thereby reducing disparities.

Connecting the dots between efforts, understanding how the populations and issues intersect, recognizing how clients are impacted by systems, critically examining barriers to services, and ensuring that solutions are culturally relevant are essential to this Action Plan.

Monterey County has been working on improving their “cultural competency” for over 25 years. Over the years, strategies and solutions have been proposed, and over the years, major progress has been made and a strong foundation has been built. Currently, we are at a place to build on that foundation and reshape some of the strategies to address inequities still experienced by community. This plan and the actions within it are meant to guide the deliberate work of the Bureau towards achieving more equitable results within underserved and unserved communities. And although the Action Plan places an emphasis on specific populations, the recommendations derived from the data are by no means solutions specific to these populations – rather they are recommendations that can be applied across the board to increase impact and reduce disparities for all those whom request services from Behavioral Health.

Accordingly, to make a significant impact, there must be a change of lens, a lens that takes us from equality to equity. Principles to implement the Action Plan require authentic community engagement, common language and frameworks, and a paradigm shift (the “shift”) that requires moving from “business as usual”—and moving from doing things right, to doing the right thing. We connected with community members with lived experience to hear their stories and ask them what they believed the barriers to service were, and for suggested solutions. Critical to shaping the path to making this fundamental
“shift” was the need to name and understand dynamics that underpin the barriers, and in doing so find ways to improve, enhance, or offer additional strategies for improving behavioral health services and outcomes in the County.

How to Use the Document and Road Map

The document is intended to guide the implementation of the MCHD BHB CCPR. Behavioral Health Cultural Competency Plan Requirement. However, the document can serve beyond MCHD BHB (Appendix 1) as the issues addressed impact clients in other systems. The document can also be used to train staff, engage community members, and inform policies.

The Action Plan draws on the data collected and begins with “snapshots” of the populations focused on. These snapshots include some population demographics, descriptive narratives, as well as resiliencies. Then, findings are discussed regarding issues, needs, barriers and suggested solutions for general populations. Details are provided for the specific populations and include staff perspective and themes derived from a MCHD BHB staff focus group.

The plan culminates in how to apply all the data with specific recommendations organized by three priorities: 1) Improve Equity; 2) Strengthen Collaboration and 3) Partnerships, and Institutionalize Cultural Relevancy and Practice/Perspective. The Plan concludes with a framework that defines the concepts and terms for creating a shared understanding and language for implementing culturally relevant services. For more detailed resources, there are five appendices, including suggested training standards (Appendix 2).

Along with the BHB CCPR Requirements, this document may use MHSA’s timeframe(s) to align programs and Action Plan recommendations. In addition, it is important to note that outcomes should be inclusive of both quantitative and qualitative measures as well as other non-traditional outcomes such as work environment, staff and community relationship building, and other systems change work that is difficult to measure but just as important. These outcomes provide an important framework that contribute to the paradigm shift of “business as usual” that can support sustainable changes to continue this work.

Connecting the Dots

The Action Plan works in congruence with the MCHD BHB Strategic Plan and is guided by the BHB CCPR and the CRHC (Appendix 3). It is important that staff, community members, and stakeholders understand the connections between different acts, initiatives, and plans that underpin the Action Plan to understand their roles and responsibilities, and fully participate in implementing the Action Plan. Each act, initiative, and plan has a specific focus, mandate, and or priority.
The California Department of Health Care Services (DHCS) (per Title 9 California Code of Regulations) established the Cultural Competence Plan Requirements (CCPR) which includes standards and criteria to be used for counties to develop their mandated Cultural Competency Plan (Appendix 4).

The U.S. Department of Health and Human Services Office of Minority Health (OMH), host The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (Appendix 5) aimed to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities. These standards inform the CCPR.

The Mental Health Service Act (MHSA) provides the funding to the California Department of Health Care Services Department of Mental Services “to support county mental health programs and monitor progress toward statewide goals for children, transition age youth, adults, older adults and families.” The MHSA informs the strategic direction of the BHB.

While the above-mentioned acts, initiatives, and plan's components are periodically updated, the spirit and intent remain constant and collectively they have a potential for a synergistic impact. The following graphic illustrates how the different efforts relate and connect to each other.
Monterey County Health Department Behavioral Health Bureau Cultural Competency Action Plan

- The Action Plan works in accordance with the Behavioral Health Strategic Plan and is guided by the Behavioral Health Bureau Cultural Competency Plan
- Cultural Competency Plan Requirements (CCPR) were developed from a compilation standards and criteria
- The California Department of Health Care Services (DHCS) (per Title 9 California Code of Regulations) established standards and criteria for the mandated Cultural Competence Plan for each county
- U.S. Department of Health and Human Services Office of Minority Health (OMH), provides The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) aim to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities
- The Mental Health Services Act (MHSA) provides the funding to the California DHCS Department of Mental Services
- The Monterey County Health Department Strategic Plan informs the Behavioral Health Strategic Plan

More Detailed Information about these documents and where to find them is included in the Appendix
Population Groups Demographics and Snapshots

Connecting the Dots Population Groups

The Action Plan is grounded on initiatives and acts that serve to target marginalized and vulnerable populations prioritized by the BHB such as those under the Community Supports and Services (CSS)\(^1\) and Prevention and Early Intervention (PEI)\(^2\) programs funded through MHSA.

Currently, the biggest gap in service penetration rate is among the Hispanic/Latino population. Only 52% of Hispanic/Latino’s are receiving services, while 75% of the population are Medi-cal eligible. Because of the low penetration rate to this population and the high rate of Hispanic/Latino families who make up the farm labor workforce, and Monterey County being one of three counties in California (Fresno and Kern being the other two) with the highest number of farmworkers\(^3\), it was concluded that including them as a population of focus would provide us with information as to barriers Hispanic/Latinos face when seeking services.

Similarly, the other identified populations were considered due to their inequitable access and their need for service coordination and linkage, as stated within the MSHA 2014 Strategic Plan. These include the hard to reach populations of homeless/displaced, LGBTQ, African American/Black, Asian American/Pacific Islander, Deaf and Hard of Hearing and System Impacted Families. Although eligible, these populations are unlikely to seek services because of their customs, ethnicity, race, sexual orientation or stigma and/or other trauma-related circumstances or events in their lives. Due to their vulnerability and need it was decided that looking at the barriers they face when seeking services was important and valuable information for the development of this Plan.

Additionally, given that the BHB system is a safety-net provider to the county’s most vulnerable and the Medi-Cal eligible, supporting efforts through the Health Department have been deployed throughout the county to enroll as many qualifying individuals into coverage to help further increase service penetration rates.

This Action Plan highlights recommendations identified by clients and community members which they feel will help extend BHB’s reach into community, decrease barriers to service and help create a more culturally relevant service delivery system that will result in more equitable services and outcomes for those needing services the most.

---

\(^1\) Community Supports and Services (CSS) are MHSA funded programs that target Children and Youth, Transitional Age Youth, Adults and Older Adults.

\(^2\) Prevention and Early Intervention (PEI) are MHSA funded programs target four specific groups: 1) unserved and underserved populations, 2) children and youth in stressed families, 3) trauma exposed individuals, 4) children and youth at risk of experiencing juvenile justice involvement.

Demographics and Snapshots

Action Plan Population Groups Demographics and Snapshots

The Cultural Relevancy and Humility Committee played a major role in identifying the populations needing to have a voice in the Action Plan. Given the considerations stated in the previous section, in December 2016, the workgroup had shortened the extensive list of populations down to the seven most critical based on the populations vulnerability and their disparate access to services. The following populations were identified to serve as focus populations for data collection phase.

Consumers, partners and community members gave input into the details of each focus group including the location, size, and specific questions to be asked. The following sections report on focus groups, key leader & community member interviews, and surveys results derived from these groups. Data was gathered between January to April 2017. The findings are not meant to be exhaustive nor are these groups meant to be a representative sample of each population. Instead, the intention is to provide a space and context to consider the barriers and solutions accounted directly from people with “lived experience” who need and acquire mental health services from the BHB.

Population: LGBTQ

Demographics

Among all U.S. adults ages 18 and over 1.6% identify as gay or lesbian, and 0.7% as bisexual. According to the national school-based Youth Risk Behavior Survey (YRBS) also conducted by the CDC 1.6% of California Students grades 9-12 identified as gay or lesbian. 6.1% bisexual, 4.9% responded not sure. A recent study conducted by the UCLA Williams Institute estimated 0.76% of the adult population or 218,400 in California identify as Transgender.

Their Story

This population shared the frustration they feel due to the lack of knowledge of different identities and common assumptions about the LGBTQ community. Participants wanted providers to understand that just as heterosexual clients have mental health concerns separate from their sexuality so do those in the LGBTQ community. Many are very


comfortable in their identity even if it is hard to share if they do not feel safe. They also shared how hard it is to open up to a provider when many individuals in this population have become used to hiding their identity. In addition, pronouns are important - committing to using a person’s chosen name and pronoun can be the dividing factor between helping someone immensely and further traumatizing them.

Resiliency Factors
This population has a very strong sense of perseverance and of self. Participants in this group demonstrated a very strong sense of personal identity and of their needs, and therefore a noteworthy ability to advocate for themselves and others. This focus group also showcased a unique support system across generations.

Population: African Americans/Black
Demographics
Four percent of clients served by MCHD BHB are African American/Black compared to 2.6% of the total population of Monterey County. 6,7

Their Story
A key community leader from the Peninsula refers to Salinas as the “other side of the river.” There is more than a geographical distance; there is also a socio-economic-educational distance between the two Black/African American communities. However, the issues of systemic racism and lack of leadership are different in both communities: the Peninsula boasts a rich history of African American-Black leadership; in Salinas there is an absence of Black/African American leadership. Both communities have dealt with the challenges of historical traumas, institutionalized racism, mental health issues, and from the focus group state they “are more frequently misdiagnosed” when compared to their white counterparts.

Resiliency Factors
Participants shared that even though the community may be small they are a force to be reckoned with, and the strength of the church community. One focus group participant shared the concept of Ubuntu: “I am because we are”. This concept speaks to the deep-rooted need for connection to the community, the value of being open to others, and knowledge that one person is always one part of a whole.

Population: Asian American and Pacific Islander
Demographics


Three percent (3%) of clients served by MCHD BHB are Asian/Pacific Islander compared to 6.5% of the total population of Monterey County.4,5

Their Story
Asian Americans include diverse populations; for our study, participants included Filipino, Japanese, from Guam and Black/Japanese and other mixed heritages. Being ostracized for being mixed is common as well as for marrying outside of the culture. Participants shared painful experiences of being made fun of, specifically their accents, and being called names. The languages spoken, food eaten, and rituals were different for the different groups. However, a common theme was that mental health issues are “private” matters.

Resiliency Factors
This population shared several resiliency factors including sharing in success - one participant said that in this community “one’s success is everyone’s success”- and the capacity to solve any problem as a group. A participant shared that in the absence of a biological family, his mother’s friends stepped in as his “aunties” demonstrating the interconnection extending beyond immediate family.

Population: Deaf and Hard of Hearing (DHH)

Demographics
There is a myth that Deaf/Hard of Hearing (DHH) children are born to Deaf parents, however, 90 – 95 % of deaf and hearing-impaired children are born to hearing parents. According to Kidsdata.org, in Monterey County 0.7% of the population is deaf, 0.1% deaf and blind, and 1.8% is hard of hearing.

Their Story
Many DHHD adults ages 20 - 60 live with their parents, have limited social contact and little formal education. A lack of awareness in the general population regarding the DHH culture leads to misperceptions about the DHH community. People will often raise their voice when communicating with a DHH person and may confuse deafness with a lack of intelligence. Sadly, many parents believe God is punishing them; some even hide the child. The general population is not aware that there are different modes and levels of communication used by the DHH community including: American Sign Language (ASL), “home sign” – invented at home and very basic, and Certified Deaf Interpreters (CDI) that are trained and certified to communicate with deaf individuals using visuals, sign language not only with hands but also face, body movements, and position. The DHH community includes all genders, race, class, sexual orientation, etc.

Resiliency Factors
Communication is quite onerous for this community; it falls upon them to get their point across and yet despite the burden they persevere and thrive. Advocates from their community make a huge difference in teaching children to stand up for themselves as

---

they advise them, “don’t nod your head if you don’t understand.” When they have people championing them - they are able rise to their brilliance a bit faster.

Population: Farmworker/Spanish Speaking

Demographics
According to the Monterey County Agricultural Commissioner,\(^9\) the Monterey County Agriculture industry directly employs 55,702 workers as of 2014; accounting for 23.7% of all jobs in Monterey County. According to the U.S. Department of Labor National Agricultural Workers Survey,\(^10\) California farmworkers are overwhelmingly male, at 76% of hired crop workers, and foreign born at 91%. Fifty six percent are technically unauthorized to work in the United States. Thirty four percent reported not being able to speak English at all, and 52% reported not being able to read English at all.

Their Story
For this population, the process of “conocimiento” (getting to know one another) was important and appeared to be very natural as they shared challenges and appreciations. Language, literacy, and physical access to clinics are repeated barriers, as well as is the cross-cultural communication. The concepts of “saludando” (greeting/acknowledgment) is very important, as is “educación.” While educación literally translates as education, in the context of basic human interaction it refers to how people interact/treat one another and is distinct from formal education. The lack of understanding the underpinnings of communication creates a disconnect. For example, a client that seeks services with a presenting issue that is exacerbated by homelessness and is monolingual Spanish speaking is going to need to be served in a way that considers both the lack of housing and inability to speak English. The client can fall through the cracks if the literacy level is not addressed. This becomes crucial across the continuum of care, from informed consent to following treatment and medication instructions, to showing up for services. In addition, the long work hours make it hard to access services during normal business hours and mental health stigma is still prominent in this culture, but with the appropriate outreach, the community may be open to services.

Resiliency Factors
The focus group shared several resiliency factors within their community including strong families, religious customs, caring for and helping others, and the determination to navigate unfamiliar systems.

Population: Homeless/Displaced


Demographics
According to the 2015 Homeless Census there were 2,308 homeless individuals in Monterey County.\textsuperscript{11} One percent censused homeless reported being under the age of 18, 9% between the ages of 18-24, and 90% over the age of 25. Forty nine percent identified as male, 50% female, and 1% transgender. Nineteen percent self-identified as LGBTQ; of those - 37% bisexual, 29% lesbian, 17% gay, 7% queer, and 5% transgender. Thirty five percent of the total homeless population identified as Hispanic/Latino, 47% white, 15% Black/African American, 4% Asian/Pacific Islander, and 34% other or multi-racial. Sixty percent reported experiencing homelessness previously and 6% were veterans.

Their Story
Focus group participants were diverse and identified with a wide variety of populations and communities. Participants “hopes and dreams” include having financial stability, getting married, having pets, and education. They strive to use their “personal experience”, to help others “find fulfillment” and be positive leaders in the community. Relationships/family are of significant value to them: a couple of participants indicated that they want to “find someone to marry who can make me happy.” Another wants to “see grandmother get well.” One participant indicated she wants to “be a grandma.” They yearn to accept and manage their mental illness: to “hope for something - haven't had hope in a long time.” Participants indicated that they have lost jobs and employment opportunities due to their “symptoms.” Others indicated they were “tired of being treated differently” and have “felt treated like a kid not an adult”.

Resiliency Factors
Participants shared resiliency factors of the many populations with which they identify including looking at things in a positive way or “turning negatives into positives” and often prioritizing helping others. Several of the participants, who identified as Hispanic/Latino/a, shared that their culture is emotional and sensitive, hardworking, and has honest traits that follow someone through all stages of their life.

Population: System-Impacted Families
Demographics
It is hard to pinpoint exactly how many families were negatively affected by systems in Monterey County. The Justice System and Child Protective Services were two systems that participants noted. There were 12,873 arrests in Monterey County in 2014, .04% were children under 10, 11% were between 10-17 years of age, 89% were between 18-70 years of age, and .5% were over the age of 70.\textsuperscript{12} In the 2014-2015 program year, reports were made to the 24-hour Child Protection Services hotline on behalf of 2,256


children.\textsuperscript{13} Out of which 61\% of those cases, a community family resource specialist offered support to the family but there was no substantiation of the alleged abuse and, in 7\% of the cases, there was substantiation of the report and the child may have been removed from their home.

\textit{Their Story}
System-impacted families are community members and they or their families use MCHD BHB services, and interact with multiple other systems including: social services, health services, law enforcement, educational institutions, and more. Due to their continued poor outcomes and lack of coordinated services, this group continues to fall between the cracks. Participants of this population group shared feeling “oppressed, depressed, sad, angry, and helpless” as a result of interactions with these systems, and of their neighborhoods and communities. It was also very important for participants that providers understand their lived experiences, have some similar experience themselves, and be welcoming to people/children with multi-cultural backgrounds.

\textit{Resiliency Factors}
This group discussed their openness to alternative behavioral health supports including art, yoga, physical activity, going outdoors, and diet.

Overall Findings Across Focus Groups

DATE RANGE OF DATA COLLECTION: January 12 to April 12, 2017

Cultural relevancy is grounded in understanding the distinct practices, strengths, needs, experiences, and interests of different groups, and “meeting the client where they are.” While each group has its unique experiences, there are also many overlapping and related dynamics to all groups. In the section below common themes across groups are highlighted.

Seven focus groups were conducted, one from each of the following groups: LGBTQ, Homeless, Farmworkers/Spanish speaking Latinos, African American/Black, Asian American/Pacific Islander, System impacted families, and Behavioral Health staff. There were 10 key informant interviews including community leaders, employees, and service providers. Attendees of an African American/Black Wellness conference on the Monterey Peninsula were asked to complete a brief survey with questions relating to cultural competency and Monterey County Behavioral Health services.

Themes and findings were summarized across groups; then tables were created for each specific group to provide greater detail of their experiences and feedback.

Themes Across Groups

All focus groups were asked about their experiences with behavioral health services - what went well, what made them feel uncomfortable, and barriers to receiving services. Again, the findings are by no means intended to be exhaustive nor represent the entire populations mentioned. Instead, the intent is to gather feedback and information, through their lens, into barriers and solutions for system improvement.

Some of the group participants expressed satisfaction with the services, finding them helpful, particularly with the willingness to provide interpreters. When asked, “what makes you feel comfortable?” participants responded:

- Bilingual/bicultural staff that understand the culture
- Very personable translation
- The secretaries and entire staff treated me with respect
- Forming the relationship with the client and get to know the person: “the person took the time to have a conversation”

Barriers
At the same time, they described the environment as being sterile, feeling like they were an inconvenience and left unattended to in the lobby. They said it could be a different experience if it was less complicated to obtain services. They were asked what gets in the way of you seeking care or getting services?" The most cited barriers to accessing services derived from the Wellness Survey were:

- Knowledge of what is available
- Stigma
- Accessibility (transportation, hours of operation, location)
- Lack of Insurance

In the focus groups, we heard the following barriers:

**Non-welcoming environment**
- Services rushed
- Frequent change of doctors
- Observing what appears to be low moral with services providers
- Often greeted with "a stare"
- That no one looks like me
- Stigma: a sense of embarrassment, that people will judge me, stereotypes, that someone will see me entering the clinic

**Lack of client knowledge**
"We have questions. Where do we get answers?"

- Not knowing who to go to and where to find them.
- Not having a place to find help/resources.
- Not being able to find providers who are well versed in issues impacting populations.

**Lack of services for follow up**
One client shared that she had declined services and stated: "I may be going crazy, but I have my family."
Another shared: "I only went to two sessions and the clinic staff never asked why [I wasn't] able to attend."

- The need to feel they matter/be recognized is demonstrated through caring follow-up.

Focus group members expressed their own difficulties as barriers:

- "I need these services and want to learn more about them, however, sometimes the barrier is time or feeling anxious to talk about my anxiety."
- "[Fear they] are out to get me."
• Some clients shared about the use of drugs and alcohol to cope with the gaps (lack of medication, lapse in services, wait time, and limited access to services) seeking assistance in “accessing wrap around services”

**Insurance/Medi-Cal**
• **Communication:** Trying to leave a message for Medi-Cal leads to an ongoing circle. One participant was stonewalled when trying to call Medi-Cal and could not get through to anyone.
• **Strict guidelines:** Insurance was dropped because participant got a job or did not get paperwork turned in on time.
• **Treatment of Medi-Cal clients:** Some feel that clients who use Medi-Cal are treated differently. However, one participant used Medi-Cal in Marina and felt that the service worker did everything they could to get the participant the services they needed.
• **Lack of money/resources:** Not having money or insurance is more stressful.

**Resiliency Factors**

With this understanding of how people perceive and access behavioral and mental health services, we turn to *alternative strategies and resources* in the community that reflect participants’ resiliencies to help cope with behavioral and mental health issues. While some apply more to one group or another, the strategies and resources may apply across groups as well.

**Strengths clients embody:**
• Don’t make assumptions
• Looking at things in a positive way
• Reaching out to others
• Turning negatives into positive
• Culture is emotional/sensitive
• Hardworking
• Honest
• Prioritize helping others

**Religious and spiritual practices:** Religious institutions, prayer, religious customs, spiritual and inspirational reading

---

**In their own words…**

“Prevention is critical, because by the time [we’re] asking for help—too late.”

“It’s necessary to address physical ailments that can become mental health issues.”

“Lack of work leads to stress, leads to depression”

“…here there are more services and insurance than in other countries”

---
Paying attention to physical health: Nutrition education, access to fresh fruits and vegetables, cooking well-balanced meals

Connection with others: Go out to the community; engage with others by talking to friends and families, support groups (like the focus groups of this project); services in the schools (PTA); training and presentations that bring people together on topics that are relevant to them

Family: family ties and celebrations; desire to connect with family; desire to have own family

Observations and Participant Recommendations/Solutions

Focus group participants had many ideas about improving access to mental health services. In the section below are some of the client's voices and their perspectives. They identified needs and the approaches that they feel would help reduce some of the barriers to accessing services. A strong understanding of the service needs, coupled with the supportive environment aspects they are looking for, will likely improve access for people of different and diverse backgrounds and experiences.

Suggestions to Improve Access to County Mental Health Services

Coordination and tailoring of services and resources

- Capacity building: training members of the community to do peer to peer support counseling
- Follow up: better tracking of clients, and in the language that the client speaks
- Appropriate level of services and resources: go directly to places accessible to people (not only in hospitals and clinics)
- Support groups for specific groups
- Special insurance covering mental health services for low income clients
- Services for family or couples
- Consistency in service provision; for example, avoid constant change in doctors – or reduce number of different doctors seen.

Outreach to the community

- Offering support groups that go out to the Community (example: “as this group today”)
- “Continue dialogues like this with professionals”
- Newsletters in schools and agencies regarding resources and support groups
- Counseling available in schools with more intention and faster appointments (should not take months and years)

Scheduling
• “To wait 3 months for an appointment is too long”
• Schedules that work for people that work in the field (farmworkers, packing sheds, etc.)
• Increase Saturday hours; currently available once a month
• Clinics that stay open until 7:30 at night
• Appointments with a secured time to not have to wait hours to be seen
What do MCBH staff/clinicians need to know about clients and their service needs?

**Client service**
- First point of contact is the most important!
- Better services from receptionist: “they treat clients as if they are less than”
- More training regarding customer services in clinics and hospital
- County staff needs to be more welcoming and make contact with clients
- Understanding that “it is really, really hard to seek these services.” This may not be the person's first time receiving mental health services, or it may be. Often clients who have received services before may have been traumatized or had some sort of negative experience

**Hiring**
- Hire more people with personal, “lived experience”
- Employ more counselors to meet the high demand
- Hire employees that are bicultural and sensitive to the culture and beliefs of the community

**Environment**
- Rushed services can exacerbate conditions of anxiety therefore making the need for service providers to slow down extremely critical
- Shift from sterile environment to a warm welcoming environment by offering water, “a piece of candy,” a friendly greeting, a slower pace, “a greeting from the heart instead of checking a box”
- **Address client concerns about confidentiality** - Just because you don’t feel safe to answer sensitive questions on an intake form doesn’t mean there isn’t something you would like to address with the provider
- Don't put pressure on clients
- Going to a doctor makes people feel intimidated and vulnerable already

**Medication**
- Just because you seek services doesn’t necessarily mean you want to be on medication
Population Specific Findings

The following seven tables provide more population specific information from each of the focus groups.

### African American/ Black

“We need to see faces that look like us. Understand our journey. Not looking down at us. Understand the language.”

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sense of giving resources to other ethnic groups</td>
<td>Safe space to reach out and share stories</td>
</tr>
<tr>
<td>Feeling uncared for</td>
<td>Increase compassion</td>
</tr>
<tr>
<td>Lack of community leadership and community involvement</td>
<td>Use the Strength Based perspective and care for the whole person.</td>
</tr>
<tr>
<td>The river [the divide between Salinas and the Peninsula] is the barrier</td>
<td>Hold an annual conference for African Americans/Blacks</td>
</tr>
<tr>
<td>to access services from the county. More than just geographical distance, a</td>
<td>Allow people to self-identify rather than having a check box</td>
</tr>
<tr>
<td>difference in class, education, and leadership between the two areas</td>
<td>Increase resources to help navigate the system (peers, handbooks)</td>
</tr>
<tr>
<td></td>
<td>Contact churches</td>
</tr>
<tr>
<td></td>
<td>Acknowledge when there are community efforts - group recognized there is a</td>
</tr>
<tr>
<td></td>
<td>need from Americans/Blacks must come together around issues impacting their</td>
</tr>
<tr>
<td></td>
<td>group</td>
</tr>
</tbody>
</table>

What staff/clinicians should know

**Do not relate to Staff**

- “We need to see faces that look like us. Understand our journey. Not looking down at us. Understand the language.”
- “Black women are raised to not show emotion…don’t deal with trauma… crushes your heart. Undealt issues cause rage…brain is going… stay unconnected…shut down.”
- “No one looks like me”
- “They have no idea what I am.”

**Intergenerational/Historical Trauma Persists**

- Historical traumas - know this and balance with professionalism
  “Need them to understand, if you are black, you've been traumatized. ...All the pressure...can’t hide my blackness.”
- Black people observe racism: afraid of police- run and hide- it is not a “crazy” reaction.
- Everybody's treated better than us

**The African American Community is limited and voice is not heard**

- There is the sense that "everything is for Latinos. They have translation for them, they don't give us none."
- “Black communities are not asked. Just the way it is.”
- Socially isolated
- Children identify Black but can't live it. Diet. Hair.

**Resiliencies**

Participants shared that even though the community may be small they are a force to be reckoned with, as is. They also spoke about the strength of the church community. One participant shared the concept of Ubuntu: “I am because we are”. This concept speaks to the deep-rooted need for connection to the community, value or being open to others, and knowledge that one person is always one part of a whole.
Asian American and Pacific Islander

“I was hurt. When you are hungry, you will eat anything. It’s a part of my culture. It’s a part of being poor.”

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Mental health issues are “private” matters and prefer not to use public services&lt;br&gt; • Not accepting mental health needs in family or not letting on that something is “wrong”&lt;br&gt; • Language barriers- need for translation or slower pace&lt;br&gt; • Experience of being made fun of because of accent&lt;br&gt; • Multigenerational trauma&lt;br&gt; • Mixed-heritage—being ostracized for marrying outside of the group.&lt;br&gt; • Socio-cultural insensitivity</td>
<td>• Strongly suggested that the County should contract with Asian American therapist in a private setting- Asian Americans “don’t want to be seen” at a county building seeking services&lt;br&gt; • Increase the number of Asian doctors&lt;br&gt; • Therapists that understand the [Asian] culture know what to ask and how to ask and what not to ask.&lt;br&gt; • Increase staff education on Asian American community&lt;br&gt; • There is the potential for the Asian American Community “to open up to County staff, but staff need to be welcoming.”&lt;br&gt; • “Translate” by speaking English at a slower pace</td>
</tr>
</tbody>
</table>

What staff/clinicians should know

**Multigenerational Trauma/Conflict is carried on**
• “Trauma passed down.”
• Being ostracized for marrying outside of the group
• Sociocultural insensitivity perpetuates the hurt today
• Some parents wanted children to speak only English.
• Some of these historical experiences that still affect us today…

**Mental Health is Extremely Private**
• Asian Americans prefer not use “county services” as they cannot be private enough
• The issue of keep things “private” is huge so has to not “shame” the family
• Do not accept mental health needs in the family
• Even within the family system, there is a tendency to “filter” and be careful about what’s said in order to avoid it being misconstrued as “something wrong.”

**Resiliencies**
This population shared several resiliency factors including sharing in success (one participant said that in this community “one’s success is everyone’s success”) and the capacity to solve any problem as a group. A participant shared that in the absence of biological family his mother’s friends stepped in as his “aunties” demonstrating the interconnection extending beyond immediate family.
### Deaf and Hard of Hearing

“They don’t understand counseling from a Deaf culture perspective”

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Feelings of limited resources to discuss mental health issues because of small Death and Hard of Hearing (DHH) community</td>
<td>- Utilize Certified Deaf Interpreters (CDI) for those who do not understand ASL- CDI’s are trained to communicate with deaf individuals using visuals, sign language, facial expressions, body movements, emotions, and position. Watching to see if the person understands</td>
</tr>
<tr>
<td>- In the DHH communities, people know each other and the interpreters. This makes it hard to talk about mental health issues—they don’t want to talk in front of interpreters.</td>
<td>- To protect the privacy and confidentiality of the DHH, go outside of area to contract interpreters</td>
</tr>
<tr>
<td>- In the DHH communities, people know each other and the interpreters. This makes it hard to talk about mental health issues—they don’t want to talk in front of interpreters.</td>
<td>- Utilize counselors that understand deaf culture.</td>
</tr>
<tr>
<td>- Parent/family education</td>
<td></td>
</tr>
<tr>
<td>- Parents must be informed and reminded that if their child doesn’t HEAR their language – they must use visual language to communicate.</td>
<td></td>
</tr>
<tr>
<td>- DHHL children that grow up with families that communicate effectively are more likely to pursue higher education and obtain college degrees and better jobs.</td>
<td></td>
</tr>
<tr>
<td>- Parents must shift from limiting attitudes</td>
<td></td>
</tr>
<tr>
<td>- Sometimes parents explain the concepts incorrectly – because they are explaining from wrong/limiting perspective and unintentionally raise a child that becomes a dependent adult.</td>
<td></td>
</tr>
<tr>
<td>- Support Groups for parents to clear up misinformation</td>
<td></td>
</tr>
<tr>
<td>- Having a Deaf child can be stigmatized and lead parents to “resist” supporting their child to learn American Sign Language (ASL)</td>
<td></td>
</tr>
</tbody>
</table>

### What staff/clinicians should know

**There are several levels of sign language**

- Some clients, who need services, know only “home sign” – invented at home and very basic.
- There is a need for special interpreters when ASL interpreters do not understand client and vice versa.

**Communication frustrations can develop into mental health issues**

- Children that are not able to effectively communicate “grow up on their own” which leads to frustration, which can lead to behavioral issues. If these issues are not addressed properly, they may manifest in mental health issues such as anxiety, depression, etc.
- Parents aiming to do the best they can inadvertently impede their child’s ability to grow intellectually because they believe that their child is “slow” and end up doing even simple things for them.

**Need to communicate effectively from first contact**

- Writing notes and using written materials is not effective communication if their native language is ASL and they cannot read or write.
- It is a common problem that DHH clients do not understand prescription dosages and consume incorrect amounts of a prescription.

**There are intersections of DHH community**

The DHH community includes all genders, race, class, sexual orientation, etc.

<table>
<thead>
<tr>
<th>Resiliencies</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication is quite onerous for this community, it falls upon them to get their point across and yet despite the burden they persevere and thrive. Advocates from their community make a huge difference in teaching children to stand up for themselves as they advise them; “don’t nod your head if you don’t understand.” When they have people championing for them, they are able rise to their brilliance a bit faster.</td>
<td></td>
</tr>
</tbody>
</table>
Farmworker/ Spanish Speaking

“Tienen que ser educados mas en como tratar a una persona.”

“They have to have more education on how to treat people.”

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Stigma: it is taboo in the community to</td>
<td>● Support groups that go out to the community</td>
</tr>
<tr>
<td>seek services, a sense of embarrassment,</td>
<td>● Resources in places accessible to people (not only in hospitals</td>
</tr>
<tr>
<td>that people will judge</td>
<td>and clinics)</td>
</tr>
<tr>
<td>● Language: greeted in English</td>
<td>● Extend Hours - Stay open until 7:30pm</td>
</tr>
<tr>
<td>● Resources: Not having money or insurance</td>
<td>● Reduce Wait Time by employing more counselors to meet the</td>
</tr>
<tr>
<td>● Transportation: not having the resources</td>
<td>high demand</td>
</tr>
<tr>
<td>to get there</td>
<td>● Training members of the community to do peer to peer counseling</td>
</tr>
<tr>
<td>● Immigration Status: Fear of new immigration</td>
<td>(capacity building)</td>
</tr>
<tr>
<td>laws in the USA</td>
<td>● Employees that are sensitive to the beliefs of the community</td>
</tr>
<tr>
<td></td>
<td>● Bilingual information written in large letters</td>
</tr>
<tr>
<td></td>
<td>● Better services from receptionist- more training regarding</td>
</tr>
<tr>
<td></td>
<td>customer service, moral support</td>
</tr>
<tr>
<td></td>
<td>● Have someone from MCHD’s BHB go out into the community to</td>
</tr>
<tr>
<td></td>
<td>conduct presentations, education, or conduct psychosocial</td>
</tr>
<tr>
<td></td>
<td>sessions in group settings.</td>
</tr>
<tr>
<td></td>
<td>● Higher coordination of behavioral health services in school,</td>
</tr>
<tr>
<td></td>
<td>this process is not easy to get through for monolingual Spanish</td>
</tr>
<tr>
<td></td>
<td>speaking people</td>
</tr>
<tr>
<td></td>
<td>● Newsletters and counseling available in schools</td>
</tr>
</tbody>
</table>

What staff/clinicians should know

Be Cognizant of the Agricultural Season
August-December the season is over and needs change
● There is less income in the home (lack of money)
● People have more time on their hands (able to go seek services)
● Holiday related stress (miss family from their native homes, if immigrant)
● Separation anxiety (miss parents, family member’s funeral, if immigrant)
● Increased stress overall
● Groups should be flexible and held when kids are in school

Need Guidance in Community
● The community is open in talking about behavioral/mental health issues and they need someone to guide/support them through
● We do not accept that we need services
● Taboo in the community to seek services

Resiliencies
The focus group shared several resiliency factors within their community including strong families, religious customs, caring for and helping the determination to navigate unfamiliar systems.
### Homeless/Displaced

“You have to be very high functioning and assertive to get what you need - that is not fair to this group”

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Suggestions</th>
</tr>
</thead>
</table>
| • Customer Service  
  o Customer Service Center negative towards some of the clients  
  o “Secretary was aggressive and asked questions the seemed extremely personal”  
  o “They [those as the front desk] don’t have the experience they need and feel they are better than us”  
  o Feels like a visceral problem  
  o People are rude and it is hard to not let it affect you  
• Walk In/ Intake process  
  o There was a block right when participant walked in the door and left without getting services [in regards to the walk in/ intake process]  
  o Often leave depressed, triggered, and without services  
• Judgment by providers about using recreational drugs  
• Basic needs: the cycle of depression - how can someone hold a job without having a place to rest and prepare for the day | • Simplify intake process and decrease amount of paperwork  
• Personal information about diagnoses should be talked about with psychiatrist only not with front desk personnel.  
• Respect and autonomy: treat [us] with respect and like an adult  
• More support groups: monthly support groups, grieving group and anger management.  
• Continue gathering feedback like this to know how to serve us. Continue focus groups like this  
• Send mental health professionals down to talk to shelters/non-profits to teach them how to deal with those who have mental disabilities. |

### What staff/clinicians should know

**We deserve to feel safe - emotionally and physically**
- Those who have mental disabilities often get mistreated in shelters and need advocates  
- [Need somewhere] “Clean and run properly. We want to be safe. We have a right to be safe.”  
- Ensure shelters are safe  
- More respectful of difference  
- Be open to how we communicate  

**Need to feel that services are completely confidential**
- What we say should be confidential [when obtaining services]  
- The intake form is invasive and asks too many questions- makes participant feel like the information is shared with staff other than direct service provider is not confidential  

**Services should be more accessible**
- “It is like pulling teeth to get what you need”  
- Often leave “depressed, triggered, and without services”  
- “You have to ask the exact right questions at the right time to get anywhere”

### Resiliencies

Participants shared resiliency factors about the many populations with which they identify including looking at things in a positive way or “turning negatives into positives” and often prioritizing helping others. Several of the participants, who identified as Latino/a, shared that their culture is emotional and sensitive, hardworking, and honest- traits that follow someone through all stages of their life.
LGBTQ

“Many of us are very comfortable with our identity. It is possible to have separate and distinct mental health concerns.”

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Misinformation and inconsistent information provided to clients</td>
<td>• Ask right away what client would like to be called and commit to use it</td>
</tr>
<tr>
<td>• Providers not up-to-date with newest Diagnostic and Statistical Manual of Mental Health Disorders (DSM) and transition procedures</td>
<td>• Ask &quot;where do you identify on the LGBTQ Spectrum&quot;</td>
</tr>
<tr>
<td>• Not being able to find providers who are well versed in LGBTQ</td>
<td>• Ability to self-identify with staff and on in-take forms (See Planned Parenthood)</td>
</tr>
<tr>
<td>• Having to teach the provider and “prove” you are trans</td>
<td>• Identify expert staff on LGBTQ so patient can request them</td>
</tr>
<tr>
<td>• Medi-Cal issues, lack of insurance, confidentiality</td>
<td>• Connecting with knowledgeable organizations like the Epicenter</td>
</tr>
<tr>
<td>• Providers often assume that being LGBTQ is the cause of the mental health issues/reason for visit</td>
<td>• Have a private entrance to avoiding having to walk by everyone else.</td>
</tr>
<tr>
<td>• Many people do not know the clinic exists.</td>
<td>• Therapy groups for LGBTQ</td>
</tr>
<tr>
<td></td>
<td>• Increase &quot;safe space&quot; visibility</td>
</tr>
<tr>
<td></td>
<td>o Be gentle- Provider does not necessarily need to be queer themselves but need to come from the perspective of knowing that client may have been traumatized in the past</td>
</tr>
<tr>
<td></td>
<td>• Education on different identities</td>
</tr>
</tbody>
</table>

**What staff/clinicians should know**

**We need to feel Safer**

• Just because you don’t feel safe to answer sensitive questions on a form doesn’t mean there isn’t something you want to address with the provider
• Participant felt attacked with information based on intake form and checked out.
• Often we try hard to fool everyone, it is hard to drop that wall when you are with a doctor
• Often patients have tried to receive services in the past and may have been traumatized - not always new to MCHD BHB services

**It’s very hard to find someone versed in LGBTQ issues**

• It’s better to turn down a client then traumatize a client you are not prepared to serve
• Being called birth name or birth pronoun (rather than chosen ones) can be hurtful and traumatizing
• Very tired of explaining what LGBTQ/non-binary is
• “Going to therapy is so much work on my own part” [in reference to having to teach the provider about LGBTQ issues]

**Don’t make assumptions or pressure patients**

• Going to a doctor makes people feel intimidated and vulnerable already
• Providers throw patients on medication and forget they are people
• Just because you seek services doesn’t necessarily mean you want to be on medication
• Pronouns are extremely important- do not assume you know
• Assumptions about being sexually active, sex of your partners, relationship status based on sexual activity, that you can get pregnant from the sexual activity, or that because you cannot get pregnant based on your sexual activity that sexual health does not need to be addressed

**Resiliencies**

This population has a very strong sense of perseverance and of self. Young participants in this group demonstrated a very strong sense of their personal identity, their needs, and therefore a noteworthy ability to advocate for themselves and others. This focus group also showcased a unique support system across generations.
System Impacted Families

“System had impact on me due to lack of support and not enough staff to follow up on situations that may occur and not enough support in helping people meet their goals”

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had to change therapist not good fit for her (daughter) – didn’t understand her – “she’s emotional reactive”</td>
<td>Better Communication</td>
</tr>
<tr>
<td>Impacted by multiple systems</td>
<td>Utilize Alternatives</td>
</tr>
<tr>
<td>Services not available when needed</td>
<td>o Less medication, more access to healthy food and holistic therapies</td>
</tr>
<tr>
<td>Not having environments/series that deals with whole family</td>
<td>o Courses on how to eat healthier</td>
</tr>
<tr>
<td>Haven’t healed</td>
<td>o Diversify the language and culture of health</td>
</tr>
<tr>
<td>Gender bias</td>
<td>o Integrate art-based therapy and outdoors therapy- Use art and nature as</td>
</tr>
<tr>
<td>Not valued</td>
<td>a tool to understand and address mental health challenges</td>
</tr>
<tr>
<td>Lack of programs for multicultural families</td>
<td>Housing</td>
</tr>
<tr>
<td></td>
<td>o Housing for homeless where they do community service projects to make</td>
</tr>
<tr>
<td></td>
<td>a difference</td>
</tr>
<tr>
<td></td>
<td>o Create affordable housing for youth and people dealing with mental</td>
</tr>
<tr>
<td></td>
<td>health challenges and have therapists on site</td>
</tr>
<tr>
<td></td>
<td>Bring Services to community</td>
</tr>
<tr>
<td></td>
<td>o Train community residents to be first responders</td>
</tr>
<tr>
<td></td>
<td>o Medication available to communities through mobile units</td>
</tr>
<tr>
<td></td>
<td>o Have more therapists in schools to help youth</td>
</tr>
<tr>
<td></td>
<td>o Create a welcoming environment</td>
</tr>
<tr>
<td></td>
<td>o Be more welcoming to all incoming guests –first impression the biggest</td>
</tr>
<tr>
<td></td>
<td>o Environments with multicultural diversity to continue healing historic</td>
</tr>
<tr>
<td></td>
<td>trauma</td>
</tr>
<tr>
<td></td>
<td>Support the whole family</td>
</tr>
<tr>
<td></td>
<td>o Childcare for parent seeking behavioral health services</td>
</tr>
<tr>
<td></td>
<td>o Support open adoptions that allow extended family relations to culture</td>
</tr>
<tr>
<td></td>
<td>o Grandparent rights</td>
</tr>
<tr>
<td></td>
<td>o Quick turnaround to see a therapist</td>
</tr>
<tr>
<td></td>
<td>o Therapist - need to learn cultural competence and develop understanding</td>
</tr>
<tr>
<td></td>
<td>of kid of color</td>
</tr>
<tr>
<td></td>
<td>Therapist with real lived experiences</td>
</tr>
</tbody>
</table>

What staff/clinicians should know

Cultural Intersections
- Diversity in the language and culture of health
- “Be intersectionally”, culturally awake
- “White therapists working with kids of color—not right”
- Need to translate culturally for “kids from the streets”

Cultural translation lacking – with secretary – then therapist

**Impacted by Law Enforcement and profiling**
- I was told that after being sexually harassed by an older man that police were more worried by my brothers hurting him than him hurting me again, no charges were filed and we decided to move away. The police protected the wrong side
- Police and Community Trauma
- Discrimination, bias, oppressed, depressed, sad, angry, helpless, unworthy, silenced, stigmatized, anxiety
- Our community has become synonymous with crime. The whole hood has been profiled - if it impacts our neighbors, friends and family then we are all... by those in positions of power and decision makers

Resiliencies
This group discussed their openness to alternative supports including art, yoga, physical activity, going outdoors, and diet.
Families and Youth

“You have to be very high functioning and assertive to get what you need- that is not fair to this group”

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Being deprived of autonomy as a youth</td>
<td>• Culturally relevant child care</td>
</tr>
<tr>
<td>• Participant asked sensitive questions in front of parents and did not feel like they could answer them truthfully</td>
<td>• Need elder care as well</td>
</tr>
<tr>
<td>• As a youth the dread of waiting for the insurance bill to come to the house because parents will them ask them about the service they received enough to keep them from seeking services</td>
<td>• Cultural translation needed more</td>
</tr>
<tr>
<td>• Transportation- youth often don’t have their own reliable mode of transportation</td>
<td>• Have more therapists in schools to help young people</td>
</tr>
<tr>
<td>• In school - counselors did not put effort to see my potential. Counselor gives different advice to different kids. Because of that I doubt myself</td>
<td>• Having an environment that deals with whole family</td>
</tr>
<tr>
<td>• Lack of programs for multicultural families</td>
<td>• Integrate art-based therapy to families and youth</td>
</tr>
<tr>
<td></td>
<td>• Family outdoors therapy</td>
</tr>
<tr>
<td></td>
<td>• Create housing for youth in Monterey County</td>
</tr>
</tbody>
</table>

What staff/clinicians should know

**Do not have the same resources and opportunities adults have to**
- Using parent’s insurance is a huge barrier
- Youth do not always have their own reliable mode of transportation

**Do deserve the same autonomy and confidentiality afforded to adults**
- Should be asked sensitive questions in private
- Itemized bills are not confidential
- LGBTQ groups participants told they were going through a phase or having to “prove” their identify

**Need support for the family as a whole**
Schools a great place to reach youth, families- especially families with language barriers
**Staff Summary**

Behavioral Health Bureau (BHB) staff from various branches contributed, in various capacities, to the development of the Action Plan. BHB staff included participants from Quality Improvement, MSHA programming, and BHB training and development. Staff maintained a continuous presence at the Cultural Relevancy and Humility Committee and subcommittee meetings, they supported focus group recruitment efforts, participated in formal and non-formal conversations about cultural competency and were included in focus groups and in a key informant interview.

The Behavioral Health focus group had a total of 19 participants: three Case Coordinators, five Supervisors, one Support Staff Supervisor, six Managers, two Deputy Directors, one Program Administrator, and one Social Worker III. Data was collected on April 17, 2017. They were asked a series of questions that led to a rich discussion about their definitions of equality versus equity, barriers and solutions to providing culturally relevant services, challenges and solutions for supervising a diverse group of employees, and how to best welcome a diverse community. Below are highlights on some important points staff raised and shared during the session.

The group made an earnest effort to work through defining and contrasting equality and equity. As the group worked through these concepts, they began to tease out some of the underlying complexities that providers and clients face in achieving culturally appropriate (possibly equitable) services. Notably, the group identified many of the same barriers and solutions that were raised in the client focus groups. These parallels show the potential for greater alignment within the client/practitioner relationships. Staff took the opportunity to articulate their own personal biases that, in addition to systemic and institutional attitudes and practices, reinforce the issues that get in the way of serving a culturally and racially diverse population.

In practice, they recognized the need to develop more trust with communities and to demonstrate their desire to reconcile the issues raised by both groups. BH staff understood the need to connect more with the community as a way of learning and in order to move toward a culturally relevant practice. Other issues they identified (from a longer list) include: being more open, hiring staff with shared lived experiences, and creating a safer space to share fears and concerns. Staff at the focus group recognized that this work needs to be done, and that it is an ongoing process—one that requires continuous learning and asking hard questions about how to be more culturally relevant. The focus group conversation showed a strong understanding and desire to more intentionally build a perspective of equity within their own practices and within each level of the bureau.
Recommendations

In the MCHD BHB Strategic Plan, there were key strategies identified to “reach their quality improvement goals.” Similarly, this Action Plan has included recommendation and steps that focus on three priorities to: 1) build on the strategies that are identified in the above-mentioned Plan, 2) were overarching themes in our findings, and 3) address the CCPR. Within each priority there are recommended focus areas of work.

The priorities, focus areas and action steps are intended to be used in conjunction with BHB aims and initiatives that support work in underserved and unserved population groups. The recommendations are designed to be used in conjunction with the cultural relevancy framework and training standards, and share the MHSA time-frame(s) to review strategy alignments.

Although most Federal and State requirements ask for the majority of the data to be measured and reported in quantitative measures, it is important to be aware of the crucial value of non-traditional measures (environment, relationship-building, etc.) which can support moving towards a paradigm shift from doing things right, to doing the right thing.

Priority 1: Improve Equity

Focus area: Intake, Transportation, Interpretation, and Access  CCPR: Criterion 8: Section D1-3

Action – Improve intake process:
- Include option to self-identify: for example: nationality, displaced (homeless), and on the LGBTQ spectrum
- Encourage client to choose preferred language
- Provide space to choose preferred pronoun and preferred name (which may be different than legal name)
- Include questions regarding mode of transportation on intake form and train and direct staff to utilize when scheduling appointments (to avoid long wait time and missed or late appointments) and making referrals

Action – In consultation with the CRHC and CRHC workgroups, assess and or create and set standards for linguistically and culturally relevant outreach material that identifies services, uses strength-based images and words that depict resiliencies. CCPR: Criterion 1: Section II, A and B; CCPR: Criterion 4: Section I: Section A-B

Action – Improve access by ensuring client tracking so that follow up is provided in a culturally appropriate and timely manner. Track, measure and report on a quarterly basis. CCPR: Criterion 2: Section I, General Population
Action – Monitor continuous self-assessment and guidance with the assistance of the CRHC to ensure linguistically and culturally relevant services from first point of contact and throughout the process.

Action – Create and support navigation systems:
- Select navigators that have lived experience, reflect the populations served, and understand consumers’ resiliency and service needs (for example, “systems navigators,” and Promotores) CCPR: Criterion 7: Section I
- Train, support, and set standards for system navigators training including but not limited to: knowledge of population served and their needs, advocacy skills, communication skills, and referrals skills. CCPR: Criterion 8: Section D3

Focus area: Environment

Action – Allow for entering from a separate entrance that provides safety for those that don’t want to be seen receiving services. CCPR: Criterion 7: Section I

Action – Provide welcoming environment that reflects the diversity of the clients, cultural art, images, and heritages, visible and accessible signage, and educational activities such as videos and books. Provide greeters. CCPR: Criterion 8: Section II: Section D

Focus area: Confidentiality

Action – Protect client confidentiality when utilizing interpreters in communities where “everyone knows everyone” (such as the Deaf and Hard of Hearing) by finding practitioners from outside the locality.

Focus area: Client Feedback

Action – Continue using focus groups as a tool to solicit client feedback.

Action – Survey current Behavioral Health clients regarding satisfaction, concerns, and suggestions for improving services.
Priority 2: Strengthen Collaboration and Partnerships

**Focus area:** Increase/improve coordinated efforts between law enforcement, Behavioral Health, and communities disproportionately impacted by negative response to ensure equitable and appropriate level of resources and response to the trauma. CCPR: Criterion 1: Section II, C and Criterion 4: Rationale

**Action** – Create a coordinated Monterey County wide community response team serving in the different supervisorial districts/jurisdictions, that will:

- Identify disproportionately impacted communities.
- Include members from the community that are disproportionately impacted as part of the team.
- Prepare the team to understand their roles, responsibilities, and responses. In addition, offer training on emergency preparedness, conflict resolution, crisis intervention, and strategies for de-escalation, and ensure bystander safety.

**Focus area:** Strengthen client and community involvement and engagement CCPR: Criterion 4: Section I, A

**Action** – Create capacity building opportunities within the client community, led by peers, for peers, for example peer support groups. CCPR: Criterion 4: Section I, B

**Action** – Create a client equitable, participatory community engagement process that includes information, input, and inclusive decision making linked to the CRHC workgroup.

**Action** – Look for unexplored contexts to create opportunities to engage with the community to build relationships and engage in dialogue. For example, where clients gather socially but dialogue is absent such as community centers, schools, churches, etc.

**Focus area:** Coordinate efforts and roles within the Health Department to support the Action Plan and the role of the Health Equity and Cultural Competency Coordinator (HECCC).

**Action** – Support the Health Equity and Cultural Competency Coordinator (HECCC) role and include the following functions in the role:

- Align the duties of the HECCC with those of the previously held position of the Ethnic Service Manager Position as required by the CCPR
- Include the following duties in the HECCC position:
  - Serve as a liaison to the community and BH, policy makers, and stakeholders
  - Monitor evaluations, reports, and compliance on resources including funding, level and quality of services, retention, and outreach efforts
- Gather more detailed information on the causes of disparities in Monterey County
- Create and suggest innovative strategies to reduce disparities
- Collaborate with Behavioral Health Training Manager on cultural relevancy issues and Health Equity Scholars Academy (HESA) training

Focus area: Clarify the roles of CRHC and the CRHC Workgroup, and their relationship to the HECCC.

Action – Formalize the assignment of the HECCC as the facilitator of the monthly CRHC meetings.

Action – Request that the CRHC and the CRHC Workgroup assist in carrying out the Action Plan, provide guidance, and serve as resource to the HECCC.

Action – Continue the bi-monthly CRHC Workgroup and recruit new members to assist in:
  - Creating the CRHC agenda
  - Develop ideas for and coordinate quarterly events with a focus on multiculturalism
  - Assist in coordinating biannual meetings with MCHD BHB staff with a focus on strengthening relationships, providing updates, and exchanging information and ideas
  - Assist in preparing updates and reports to the CRHC

Focus area: Coordinate efforts with the goal of improving cultural relevancy and look for new opportunities to further improve equity and reduce disparities amongst Health Department, Administration, Behavioral Health, and Public Health Bureaus.

Action – Create common language and a framework for supporting culturally relevant services and advancing equity in the County; this frame should include understanding root causes of inequities, power dynamics, privilege, and systematic oppression, as well as resilience and authentic allies. CCPR: Criterion 5: Section II, A and B

Action – Create a space to have the difficult conversations and engage in authentic dialogue to build relationships, develop shared language, and make a collective shift towards more culturally relevant practices and services. CCPR: Criterion 5: Section II, A and B

Action – Conduct focus groups amongst Health Department, Behavioral Health, Administration and Public Health Bureau to hear directly from staff about their
concerns and suggestions regarding the inequities throughout the departments. 
CCPR: Criterion 5: Section II, A and B

**Focus area:** Formalize process for assessing client satisfaction and collecting and tracking data on inequities among populations for greater accountability. Involve HECCC in reviewing data and making improvement recommendations. CCPR: Criterion 7: C

**Action** – Engage QI to oversee periodical sample of client satisfaction and create a client feedback loop

**Action** – Tracking data that reflects populations that are not currently tracked or measured.

**Action** – Streamline the data so that it is easily accessible and addresses disparities and actions taken to address those disparities.

**Action** – Improve accountability within and between departments and with the community. Request that QI provide CRHC reports monitoring retention rates and access patterns as per CCPR Criterion 5 Section IIIA4; CCPR Criterion 8 Section IVB

**Priority 3: Institutionalize Cultural Relevancy Practice/Perspective**

**Focus area:** Institute a practice, set the tone, and create an expectation throughout Behavioral Health of the shift from equality to equity through and towards culturally relevant practices. CCPR: Criterion 1: Section I, A

**Action** – Operationalize “equity” framework and values by working towards agreement and greater buy-in throughout the agency. Administrators and staff work to embody the framework and values. Instituting these practices will impact the organizational culture from the “top-down” from Administration to Directors to Managers and Supervisors to Direct service staff and from the “bottom-up”.

**Focus area:** Prepare, train, and support staff to deliver services from a culturally relevant perspective. CCPR: Criterion 5: Section I, A and B
Action – Create a framework and common language to train staff.

Action – Create the time and space for staff to reflect on their training/practice moving towards equity/cultural relevancy and be supported to make changes (for example addressing barriers/challenges and visiting other counties/models)

Action – Create space for staff to dialogue and learn about cultural relevancy across positions, roles, and departments.

Action – Provide continuing cultural relevancy education consistently at a minimum of a quarterly basis.

Focus area: Carrying out the Action Plan

Action – Familiarize the CRHC and Workgroup with the Cultural Competency Plan Requirements by creating a standard item on the CRHC monthly agenda. At these meetings, they will review the plan, prioritize actions, monitor progress, set timeline for revision, and revise actions as needed.

Action – Consult the Behavioral Health Strategic Plan to avoid duplicative efforts by the implementation of Action Plan.

Action – Have the HECCC check that it aligns with the spirit of the mandated criteria.

Focus area: Define the role of the CRHC

Action – Revise the CRHC mission and update to make congruent with Action Plan process and findings, reflect on and evaluate progress, and schedule retreat to strategize for compliance with the CCPR
Conclusion

This Action Plan and its recommendations are the culmination of the intentional work conducted to bring together the various acts, initiatives and plans that guide MCHD BHB with the voices of those who receive and need its services. The populations surveyed, for this plan, were those identified as underserved, unserved and other vulnerable communities who are at higher risk and in need of culturally relevant services and supports.

This document serves as a guide to address some of barriers to access that these populations face, so as to subside them as much as possible and create a more welcoming, safe and inviting environment where people can easily access the much needed services the bureau offers.

A solid foundation is already in place and the bureau’s commitment of moving towards equity will make these actions more achievable. And although some of the barriers described by those interviewed, for this plan, will take time, especially those that require systems change work, others could be easily addressed. Nonetheless, the actions within this document can help MCHD BHB prioritize the actions said to help increase equitable and safe access for all.
Alignment of Efforts

The table below identifies some current strategies that the BHB is implementing to address some of the barriers identified by clients and community. They are not exhaustive of the current work. More information can be found in the County’s MSHA Plan and the Strategic Plan as well as the acts identified as informants to this Action Plan.

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Community Recommendation</th>
<th>Current Strategy to Help Address Issue</th>
<th>Where It’s Implemented Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some clients cannot take a day off of work because it will have cause a financial hardship</td>
<td>Provide services in the community and at community-based locations</td>
<td>12 week trail period: Late hours 9-6pm every Wednesday (July 12 to Sept 20)</td>
<td>King City—South County</td>
</tr>
<tr>
<td>Understanding homeless client’s needs</td>
<td>Work with and through people with “lived experience”</td>
<td>Through Whole Person Care peer patient navigators were hired to work with the homeless population</td>
<td>Salinas, Chinatown</td>
</tr>
<tr>
<td>Transportation</td>
<td>Provide services throughout the community in locations that are accessible to various populations</td>
<td>Using community space to hold individual and/or group therapy</td>
<td>Gonzales</td>
</tr>
<tr>
<td>Limited opportunities to share space and engage in conversations</td>
<td>Create space for staff to dialogue about cultural relevancy across positions, roles, departments</td>
<td>Used <em>conocimiento</em> during last staff retreat and plan to continue using the model to establish safe spaces for staff dialogues</td>
<td>BHB all staff</td>
</tr>
<tr>
<td>Limited language on how to discuss inequities</td>
<td>Create a framework and common language to train staff</td>
<td>Training manager is introducing equity language and framework to new staff</td>
<td>New BHB staff</td>
</tr>
<tr>
<td>Limited opportunities for client feedback</td>
<td>Conduct surveys to get community feedback</td>
<td>QI conducts 6 month surveys and reviews data to address issues and opportunities</td>
<td>QI Countywide</td>
</tr>
<tr>
<td>Limited client self-identification options</td>
<td>Include option to self-identify on forms, etc.</td>
<td>Added non-bindary option to some intake forms</td>
<td>PEI programs</td>
</tr>
<tr>
<td>Limited client self-identification</td>
<td>Include option to self-identify on forms, etc.</td>
<td>Placed unisex bathroom signage to offer more welcoming spaces for clients</td>
<td>BHB clinics</td>
</tr>
</tbody>
</table>
Culturally Relevant Framework

The following discussion and definitions of key terms and concepts provide a frame of reference for implementing the Action Plan and applying the training standards. Having a shared understanding of key terms and concepts is necessary for staff to operate from culturally relevant perspectives, to move towards more equitable service delivery, and to reduce disparities. Using a Culturally Relevant Framework requires an acceptance and understanding of the need to make a paradigm shift (or “shift”)—a fundamental change in how one sees and approaches cultural relevancy. This shift can also happen within and across organizations as they change their organizational culture.

Staff and clients show up with their respective experiences, values, attitudes, information and/or misinformation which can sometimes be in conflict. The focus group participants expressed that they were wary of whether traditional training methods can make a significant change in the feeling of being looked down upon by frontline staff. The participants expressed that the root of the problem felt personal and visceral, more than due to lack of knowledge and skills. The “shift” questions “business as usual;” it clarifies and redefines basic principles of practice such as “client engagement.” A different approach to engaging successfully with clients is based on establishing authentic relationships founded in trust and respect.

However, the practitioner must be acutely aware that actions that build trust or respect in one community can create barriers in another. In addition to building “authentic relationships,” practitioners must have the “will to act.” Acquiring skills and knowledge, while important, in the absence of using the skills with the intention and sentiment, it does not change practices. The ‘will to act’ can be motivated and supported immensely by organizational culture. Behavioral Health leadership can shape the path by directing and supporting staff to make internal changes toward equity throughout organization.

Understanding the meaning of equity is necessary for guiding cultural relevancy. While the terms Equity and Equality are often mistakenly used interchangeably they are actually two very distinct concepts. The definition of equality is the “quality or state of being equal” in status, rights, opportunities, and more. In other words, equality gives all people the same blanket opportunities (See the equal number of steps on the left).
Key Terms:

**Equity and Equality**

**Equity** addresses and removes the barriers that arise based on social determinants or socially identifying factors that may inhibit some people from taking advantage of these same opportunities. This may require additional resources or supports (See variation of the steps the picture on the right). Understanding the distinction between these two concepts is key to understanding and applying a culturally relevant framework.

**Bicultural**

Bilingual and **bicultural** are terms frequently used in conjunction with each other. It is important to note that while they may be related they are independently acquired characteristics. Being bilingual certainly does not mean someone is bicultural, and someone can be bicultural without the language skills to be fully bilingual. In addition, neither of these characteristics in and of themselves ensures a positive provider-consumer interaction even with a client or consumer who shares a similar cultural background.

Someone who is working through a bicultural lens has the ability to “find solutions beyond the mere translation of words”, “knows both cultures well enough to negotiate tensions arising from misunderstandings”, and may even anticipate “cultural conflicts and resolutions.” To be effectively bicultural in the workplace is complex. One must have the “ability to assist one’s clients, but also navigate one’s professional environment in ways that generate credibility and trust among peers.”

A study on service providers working in a Spanish speaking immigrant community revealed that serving the Latino immigrant community required more than the ability to speak Spanish and basic knowledge of cultures. Effective service delivery requires four distinct skill sets: language skills, cultural competence, empathy, and the providers will to act. Contending with institutional boundaries can hinder one’s ability to provide relevant services and can lead to frustration or isolation when dealing with colleagues, supervisors, or other agencies that do not possess the four skill sets.

**Concepts:**

**Systematic Oppression**

**Systematic oppression** is a self-perpetuating imbalance of economic, political and social power that is institutionalized. Understanding that these systems and forces impact the daily lives of many of the clients is critical. Racism, classism, sexism, heterosexism, anti-

---


Semitism, able-bodism are few examples of the commonly known “isms” associated with systematic oppression. Unless a practitioner has an awareness of such dynamics, they may fall into the trap of unknowingly colluding with the cycle of oppression.

Understanding the dynamics of Power, Privilege and Oppression that underpin systematic oppression is necessary for moving toward a state of equity throughout the Behavioral Health Bureau, the Health Department, and all Monterey County governance. Peggy McIntosh in her article White Privilege: Unpacking the Invisible Knapsack of Privilege defines privilege “as unearned advantages, entitlements, and conferred dominance.” Privilege is present all around. As a hearing person, not having to think about depending on someone else to communicate is privilege; not having to think about where one will sleep tonight or where one’s next meal will come from is also privilege. Focus group participants alluded to a sense of awareness of privilege. When working with clients, it is necessary to be aware of one’s privileges, and where it is absent.

It is often easier to blame people for their situations and believe they could change if they wanted to, than it is to examine the systems that are in place that perpetuate the inequities they may experience. Dehumanization and coded language are the glue that keeps systematic oppression in place. Seemingly innocuous words and phrases have tremendous power and play a role in dehumanizing groups of people. For example, the phrase "those people" is code for separating oneself and justifying mistreatment.

Faulted dualistic thinking forces people into an “us” and “them” perspective. Sherover Marcuse describes how groups and individuals become conditioned into the role of “being oppressed” and the role of “being oppressive.” We can contradict this conditioning by operating under the assumption that “we have done our best to resist these roles.” As they internalize these beliefs, practitioners can foster greater empathy for themselves and those they serve, also creating more opportunities to build alliances.

**Intergenerational Trauma and Microaggressions**

“What is overwhelming and unnamable is passed on to those we are closest to. Our loved ones carry what we cannot. And we do the same.”

Historical systematic oppression functions and relates to intergenerational trauma. Traumas range from ones that affect one individual to those that affect or target an entire community. Genocide, slavery, forced relocation, and destruction of cultural practices are examples of traumas experienced by communities and that can be carried across generations, consciously and subconsciously.

---

Many focus group participants identified trauma as a major barrier to service, and gave insight to the need for further investigation into how trauma is passed down between generations. Understanding the nuances of intergenerational trauma will help practitioners assist clients experiencing issues related to trauma. Failing to recognize when a client shows up with a history that includes trauma may cause a practitioner to miss the mark. As a result of this oversight, practitioners may direct the client in the wrong direction or even cause additional harm.

Historical traumas of racial and ethnic groups are often perpetuated today through Microaggressions—sometimes subtle and unconscious (sometimes not) acts of insult, invalidation, marginalization, and assault. Examples include white models wearing traditional Native American clothing or the idea of “Color Blindness,” a concept which dismisses another’s racial or ethnic background and experience. These microaggressions can be manifested in the next generation where descendants feel as though they had experienced the same trauma, feelings of guilt or victimizations, persecution. They might also feel or attempt to justify the survival of their parents to things like never standing out, social capital, or luck. These traumatic events and persistent experiences of discrimination and racism result in significant stress that can be ultimately tied to health disparities, substance abuse, and mental illness. While symptoms may not result directly from the original trauma experienced by the family, the various integrations of the traumatic experiences into the child’s life can cause the child to “experience greater trauma when faced with a new stressor.”

Intersections
Clients self-identify with specific populations and sub-populations, each presenting different resiliencies, needs and issue and interacting with different systems. Examining those different factors and their intersections is critical to a culturally relevant practice. As an example, a monolingual Spanish speaking Latina client may show up with a presenting issue that is exacerbated by being homeless. She is going to need to be served in a way that considers both the lack of housing and the inability to speak English. And if the same client is not literate, she will fall between the cracks even more so since there is a need to assess her reading level across the service continuum: from informed consent, to following a prescription regimen, to follow up.

Effective Communication
emotionally limited... less able to respond optimally during usual developmental crises and help the world to be more comprehensible to the child” thus interfering with the child’s emotional development.”


Authentic communication and listening to what was shared is an invaluable skill necessary for engaging clients and applying a culturally relevant model. A reoccurring theme throughout the focus groups was “moving from what people say, to what people mean”. Put another way, listening is much more than hearing and distinguishing between what is said and heard. “Listening” to clients, takes into account power dynamics, and the “will to act.” Effective communication moves beyond the verbal and requires looking closely at gestures, nuances, and other body language that vary from culture to culture.

Another factor critical to delivering culturally relevant services is the distinction between interpretation and translation. While a “translator” renders information from one language to another, an “interpreter” must be able to translate in both directions and understand “idioms, colloquialisms, and other culturally-specific information.” The interpreter must be able to consider the differences between conceptual and literal translation.

The Strength Based Approach
The Strength Based Approach (also referred to as the strengths based model or strengths perspective) is a philosophy that has become very popular in the last few decades and adapted for use in many fields—including social work, psychiatry, education, justice and corrections, medicine, and business. The Strengths Based Approach is “both a philosophy of practice and a set of tools designed to help people set meaning and important life goals and draw upon both personal and environmental strengths to achieve them”.

22 The Strength Based Model includes 6 core principles: people with mental illness can recover; focus on an individual’s strengths including talents, resources, aspirations

---

22 Portney, C. (2003) Intergenerational transmission of trauma: An introduction for the clinician. Psychiatric Times. Retrieved from http://www.psychiatritimes.com/articles/intergenerational -transmission-trauma-introduction-clinician “Patients with parents suffering with PTSD often describe damaged, preoccupied parents who are emotionally limited... less able to respond optimally during usual developmental crises and help the world to be more comprehensible to the child” thus interfering with the child’s emotional development.”
rather than the individual’s deficits; the community is a great resource and source of strength; the client directs the process; the relationship between consumer and provider is essential; and the primary setting of the work is the community (meaning that people do not recover in the health center but in their everyday community based environment).  

In a mental health setting, the Strength Based Approach shifts the focus from symptoms and pathology only to each individual’s unique qualities that promote health. It is recognized that utilizing the Strength Based Approach can be challenging. Providers are trained to diagnose mental illness as in any other branch of medicine by focusing on the symptoms and pathologies. And an accurate diagnosis of illness does enable a consumer to receive proper treatments and medications. However, focusing on strengths and abilities, aspirations, and autonomy gives a person tools they can rely on when they experience a stressor rather than lowering a person’s self-esteem by focusing on one’s problems and failures.

Focus group participants, time and time again, demonstrated a noticeable shift in their participation when they shared about their strengths and resiliencies—they appeared to be much more present and open. Building on strengths and acknowledging resiliencies improves client engagement, shift dynamics and allows the client to move out of the victim role toward a role of empowerment.

---


The need for a person/people to help navigate systems throughout Behavioral Health was a common theme throughout the focus groups. Service or patient navigators have been utilized throughout the country for many years and in many service contexts, whether in formal health centers or in peer-support, community based settings. Navigators often have personal experience with the systems they support others to navigate. They are recruited and trained to support cancer patients, homeless populations, people with serious mental illnesses, immigrant health care seekers, and people with disabilities, among many others.

Navigators are most effective when they are mobile and can meet people where they are geographically and emotionally in their journey. Organizations and institutions adopt the navigator model when finding that consumers face multiple barriers in accessing help or services. Such barriers often include lack of information about how to apply and qualify for insurance or other programs, and the absence of culturally responsive services.

Some specific navigation tasks include:

- Engage with people and families to quickly identify currently available services for which they qualify and are responsive to particular cultural, ethnic, age and gender identity;
- Build or strengthen relationships with service providers to facilitate communication and expedite access to services;
- Work with consumers and families to help them along the care/service continuum: insurance problems, finding providers, understanding care/service options, completing application forms, accompanying them to visits, serving as advocate, mobilizing resources, etc.
- Close the gap between shelter and housing for homeless individuals and families;
- Follow-up with people with whom they have engaged to ensure that they received the help they needed;
- Identify, mobilize and leverage unique community assets and thus strengthen the community’s capacity to help meet needs;
- Build and enhance collaborative partnerships

In 2013, the County of Los Angeles - Department of Mental Health Stakeholder group recommended the creation of Service Area Navigator Teams that would, “across age groups, assist individuals and families in accessing mental health and other supportive services, and network with community-based organizations in order to strengthen the array of services available to clients of the mental health system. Such networking would create portals of entry in a variety of settings that would make the Department’s long-standing goal of ‘no wrong door’ achievable.”

---

25 In a study conducted in 2016 on the status of Homeless Women in Monterey County, women interviewed identified the complexity of systems, referrals and application processes as difficult to understand and navigate, and one of the main barriers to accessing services.
Appendices

Appendix 1: Methodology

Questions to guide the development of the Action Plan:
❖ How do clients self-identify?
❖ Experience using Monterey County Behavioral Health services?
❖ Barriers to accessing mental health services?
❖ Alternatives to mental health services or other forms of support?
❖ What types of mental health services need to be offered?
❖ Solutions/suggestions to improve access to mental health services?

Sources of data:
❖ Conducted seven focus groups: LGBTQ, homeless, Spanish speaking Latinos, African American/Black, system impacted families, and Behavioral Health staff
❖ Approximately 90 Monterey County residents participated.
❖ Interviewed key community leaders, county employees, community members
❖ Surveyed attendees of a Wellness conference aimed at the African American Community in the Peninsula
❖ Reviewed Behavioral Health Bureau Cultural Competence Plan and Monterey County Behavioral Health Bureau Strategic Plan
❖ Literature research on key terms and concepts

Collecting data:
❖ Responses were charted and notes taken by observers and interviewer. Matrix Consulting Institute (MCI) Principal performed interviews
❖ Research and demographic data collection was performed by MCI associates.

Data analysis
❖ CRHC Workgroup assisted in the preliminary data analysis. Final data analysis was performed by MCI Associates
Appendix 2: Training Standards

One of the actions steps in the Action Plan includes the recommendation that the Health Equity and Cultural Competency Coordinator collaborate with the Behavioral Health Training Director. We are recommending training standards that will help staff to have a common understanding that will lead them to a common goal: to provide culturally relevant service delivery.

As a first step, we recommend that the Training Director identify training Cultural Competency/Cultural Relevancy models that have successfully been implemented throughout Monterey County Health Department. As a next step, we encourage the incorporation of the following considerations to institute a training standard that will assist in leading Behavioral Health Bureau staff toward a culturally relevant practice.

General Considerations
- Create a common language and framework to address equity, social justice, and the connection to cultural relevant service delivery
- Train staff on the connections between different acts, initiatives, and plans that underpin the Action Plan to understand and fully participate in carrying it out
- Train on the issues of power dynamics, systematic oppression, and privilege

Client consideration:
- Ensure that the voice of the clients is included in all training related to client services
- Address stigma from the experience and perspective of different communities
- Train to understand historical trauma of different populations
- Identify and utilize experts in specific fields impacting populations, e.g., LGBTQ, distinctive interpretation modes in deaf community, African American-Black, displaced vs. homeless, and system impacted families.
- Train using dichos/sayings from different communities to capture the cultural nuances
- Train with a focus on humanizing the client lived experience, connecting with clients with a simple heartfelt “hello,” and meet clients where they are. Using critical thinking, a strength-based approach, and humility are key to “humanizing” the client interaction.

Staff considerations
- Train on and stress communication and listening skills that are effective and cross-cultural
- In training, allow for personal reflection of own bias and experiences that may be potential barriers to offering culturally relevant services
- Support and train staff to understand the need to shift awareness and perspective from privilege to humility (See Culturally Relevant Framework)
- Create space to hold “difficult conversations”
- Offer multi-level trainings based on readiness and experience, i.e., beginning to advanced
- Require minimum annual training
- Offer optional advance training
- Develop a cohort system to encourage support, mentoring, and learning environments.
- Use movies as a training
Appendix 3: CRHC Mission Statement

**Mission:** The Cultural Humility and Relevancy Committee is working to provide a holistic approach to bring equitable service to all community members in Monterey County through cultural awareness and education.

**Vision Statement:** To ensure all Monterey County residents will have equal opportunity to reach their full health potential.

**Functions:**
1) Obtain an effective communication plan with deputy directors and health directors
2) Review and create policies
3) Receive group training for ongoing learning of culturally competent practices
4) Collaborate with others on local, regional and state levels
5) Create outcome measures, evaluations and tracking documents
6) Create networks and facilitate community outreach

**Goals:**
1) Develop relationships with the new and old directors
2) Train the committee for three to six months
3) Develop a network for unrepresented cultures
4) Provide feedback and reviews of key documents as well as give input for improvement
5) Encourage others to join the committee

All contract providers are encouraged to participate in the CRHC. Committee meetings are held at CBO’s, and at the health department headquarters. Participation on the committee by various sectors of the community is highly encouraged. The committee is continuously seeking participation by staff, community partners, consumers, family members and local activists, working to increase mental health and wellness for all. One of the key functions of members is to support the expansion of the committee to include representation of unrepresented cultures and encourage others to join the group to include fresh insights from the community.
Appendix 4: Cultural Competency Requirements

California Department of Health Care Services
http://www.dhcs.ca.gov/services/mh/pages/culturalcompetenceplanrequirements.aspx

In 1997, the former California Department of Mental Health, formed a Cultural Competence Task Force (subsequently changed to the Cultural Competence Advisory Committee) to begin developing the first set of cultural competence plan standards, to address the needs of multicultural communities by implementing culturally and linguistically competent mental health services. The 35 member team charged with developing the initial cultural competence standards, worked in partnership with the California Mental Health Directors Association and community partners inclusive of mental health consumer and family members. This was the first endeavor of its kind in the nation, recognized for pioneer leadership by the Georgetown University Cultural Competence Center. Since 1997, three evolutions of the plan have been developed and implemented culminating in the most recent version, the Cultural Competence Plan Requirements (CCPR).

The CCPR establishes further standards and criteria for the entirety of the California County Mental Health System, including Medi-Cal services, Mental Health Services Act (MHSA), and Realignment as part of working toward achieving cultural and linguistic competence. Each county must develop and submit a cultural competence plan consistent with these CCPR standards and criteria (per California Code of Regulations, Title 9, Section 1810.410). This plan shall address all mental health services and programs throughout the County Mental Health System. This CCPR seeks to support full system planning and integration and includes the most current resources and standards available in the field of cultural and linguistic competence. It is intended to move county mental health systems toward the reduction of mental health service disparities identified in racial, ethnic, cultural, linguistic, and other unserved/underserved populations. The CCPR works toward the development of the most culturally and linguistically competent programs and services to meet the needs of California’s diverse racial, ethnic, cultural, and linguistic communities in the mental health system of care.

Eight criteria were developed to encompass the CCPR and assist county Mental Health Plans (MHPs) in identifying and addressing disparities and inequities across the entire mental health system. Those eight criteria are as follows:

- Criterion I: Commitment to Cultural Competence
- Criterion II: Updated Assessment of Service Needs
- Criterion IV: Client/Family Member/Community Committee: Integration of the Committee Within the County Mental Health System
- Criterion V: Culturally Competent Training Activities
- Criterion VI: County’s Commitment To Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff
- Criterion VII: Language Capacity
- Criterion VIII: Adaptation of Services

These eight criteria are a mechanism to examine where MHPs lie on the scale of cultural competence. Having used the criteria to form a logic model, the CCPR’s development and
Appendix 5: National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard:
1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:
2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:
5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:
9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization’s planning and operations.
10. Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization’s progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.
The collaboration between the Behavioral Health Team and the Forensic Team provides critical support for patients during their hospitalization. The Forensic Team includes specialists from various disciplines to address the unique needs of patients with a history of violent or aggressive behavior.

**Forensic Team**

- Supportive services
- Mental health treatment
- Other health and safety needs
- Legal and other health-related issues
- Community involvement
- Patient/family/carer engagement
- Discharge planning services
- Additional resources
- Medication management

**MCHOME Program**

- Physical and mental health support
- Mental health care coordination
- A multitiered approach for mental health care

**Crisis Information Team (CIT)**

- Training Academy

**Critical Incident Stress Management (CISM)**

- 831-255-4111
- Team (CISM)

**Mental Health Unit (MHU)**

- Hospital-Based Emergency Services
- Older Adult Intensive Team

**Full Service Partnership Program**

- Supportive services
- Medication management
- Case management

**Nevada Team (BHTN)**

- Behavioral Health Crisis

**Crisis Information Team (CT)**

- 381-255-4111
- Team (CISW)
Behavioral Health Bureau
County of Monterey Health Department

www.mymvd.org

Sistema de Cuidado

Programas para Adultos
Del Condado de Monterey
de Salud Mental

Departamento

831-386-6986
King City, CA 93930
200 Broadway St. Ste. 70
King City

831-678-5125
Salinas, CA 93960
359 Caballero Dr.
Salinas

831-647-7652
Marina, CA 93933
299 12th Street
Marina

831-755-5505
Salinas, CA 93906
Bldg. 400 Ste. 200
1441 Constitution Bldg.

Programas para adultos
Investigaciones referentes de
Las señales son ubicaciones de

El equipo de acceso a tratamiento
System of Care
Health Services
Behavioral
Children's

Children's Behavioral Health

Clinic Locations

Clinic Locations

Behavioral Health Bureau
County of Monterey Health Department

www.mwtd.org

383-386-6836
King City, CA 95950
200 Broadway St. Ste. 88
King City

831-678-5125
Salinas, CA 93906
359 Cabrillo Dr.
Salinas

831-678-7622
Marina, CA 93933
299 Twelfth Street
Marina

831-678-7555
Salinas, CA 93906
Bldg. 400 Ste. 200
1441 Constitution Blvd.

831-796-1500
Salinas, CA 93901
1000 South Main St. Ste. 210B

831-784-2150
Salinas, CA 93901
931B Bianco Circle
Salinas

1-888-258-6029

One Number, Four Regional Offices to Serve You:

We, are here to help.
We welcome and encourage you to call

We provide mental health services as assessed on an individual basis. Additional services and supports, as well as specially available in individual and group settings, the need for

What do we provide:
Services are generally

for your care

Appointment for a mental health assessment with one appropriate community resource, or schedule an

Behavioral Health Team Member will provide you

Monday - Friday 8AM - 5PM and back with a

You can call the toll free number 1-888-258-

Salinas, Marina, Soledad and King City.

Clinic Locations in any of our four regional offices:

1. The access to Behavioral Health Clinics is the only point to

Access to Treatment
Psychiatric Services

831-784-2150

AVANZA - Transition Aged Youth (TAY) Program

Youth aged 16-23 who are no longer attending school may be eligible to participate in the TAY program, which provides mental health services through the Family and Youth Resource Center.

Services to Education Team

831-784-2150

Supportive Therapeutic Options

Youth also can participate in skills groups, outings, and recreation events. Youth also can participate in skills groups, outings, and recreation events.

In short-term and family therapy

Psychological assessments

Recreational

AVANZA (Ages 16-23 QP)

The AVANZA Transition Aged Youth program is a comprehensive, coordinated, and collaborative approach to providing mental health services to youth aged 16-23 who are no longer attending school.

The services to education team also provides:

- Social skills training
- Mental health services
- Family therapy

Services to Education Team

831-784-2150

Supportive Therapeutic Options

Youth also can participate in skills groups, outings, and recreation events.

Youth also can participate in skills groups, outings, and recreation events.

Psychological assessments

Recreational

AVANZA (Ages 16-23 QP)

The AVANZA Transition Aged Youth program is a comprehensive, coordinated, and collaborative approach to providing mental health services to youth aged 16-23 who are no longer attending school.

The services to education team also provides:

- Social skills training
- Mental health services
- Family therapy

Services to Education Team

831-784-2150

Supportive Therapeutic Options

Youth also can participate in skills groups, outings, and recreation events.

Youth also can participate in skills groups, outings, and recreation events.

Psychological assessments

Recreational

AVANZA (Ages 16-23 QP)

The AVANZA Transition Aged Youth program is a comprehensive, coordinated, and collaborative approach to providing mental health services to youth aged 16-23 who are no longer attending school.

The services to education team also provides:

- Social skills training
- Mental health services
- Family therapy

Services to Education Team

831-784-2150

Supportive Therapeutic Options

Youth also can participate in skills groups, outings, and recreation events.

Youth also can participate in skills groups, outings, and recreation events.

Psychological assessments

Recreational

AVANZA (Ages 16-23 QP)

The AVANZA Transition Aged Youth program is a comprehensive, coordinated, and collaborative approach to providing mental health services to youth aged 16-23 who are no longer attending school.

The services to education team also provides:

- Social skills training
- Mental health services
- Family therapy

Services to Education Team

831-784-2150

Supportive Therapeutic Options

Youth also can participate in skills groups, outings, and recreation events.

Youth also can participate in skills groups, outings, and recreation events.

Psychological assessments

Recreational

AVANZA (Ages 16-23 QP)

The AVANZA Transition Aged Youth program is a comprehensive, coordinated, and collaborative approach to providing mental health services to youth aged 16-23 who are no longer attending school.

The services to education team also provides:

- Social skills training
- Mental health services
- Family therapy

Services to Education Team

831-784-2150

Supportive Therapeutic Options

Youth also can participate in skills groups, outings, and recreation events.

Youth also can participate in skills groups, outings, and recreation events.

Psychological assessments

Recreational

AVANZA (Ages 16-23 QP)

The AVANZA Transition Aged Youth program is a comprehensive, coordinated, and collaborative approach to providing mental health services to youth aged 16-23 who are no longer attending school.

The services to education team also provides:

- Social skills training
- Mental health services
- Family therapy

Services to Education Team

831-784-2150

Supportive Therapeutic Options

Youth also can participate in skills groups, outings, and recreation events.

Youth also can participate in skills groups, outings, and recreation events.

Psychological assessments

Recreational

AVANZA (Ages 16-23 QP)

The AVANZA Transition Aged Youth program is a comprehensive, coord
Sistema de Citigado

Adolecentes
Ninos y
Programas Para
Del Condado de Monterey
Departamento de Salud Mental

831-386-8836
King City, CA 93930
200 Broadway St Sf, Ste 88
King City

831-678-5125
Solvang, CA 93460
359 Caballero Dr.
Solvang

831-647-7652
Marina, CA 93933
299 Twelfth Street
Marina

831-735-5505
Salinas, CA 93906
Bldg 400, Ste 200
1441 Constitution Blvd.

831-796-1500
Salinas, CA 93901
1000 South Main Sr, Ste 210B
Salinas

831-744-2150
Salinas, CA 93901
5STB Blanco Circle,
Salinas

Por que el cuidado de nuestras mentes es esencial.

Estamos aqui para ayudar.

1-888-258-6029

Si se siente en peligro, llame al 911.

Si necesita ayuda para programar, llame al 831-796-1500.

Si tiene una emergencia mental, llame al 1-888-258-6029.

Si necesita asistencia para un problema mental, llame al 831-386-8836.

El equipo de acceso a Tratamiento es el grupo de personas que nos ayudan a recibir el tratamiento adecuado.

Las personas con trastornos mentales reciben el tratamiento adecuado.

El programa de Tratamiento es el grupo de personas que nos ayudan a recibir el tratamiento adecuado.
Los servicios de apoyo y orientación a la familia se entregan en coordinación con el médico y el profesional de enfermería. Los servicios de apoyo están diseñados para brindar soporte emocional y práctico a las familias durante el proceso de supervisión. Los servicios de apoyo pueden incluir la planificación de visitas, la coordinación de citas médicas y la asistencia con tareas diarias.

Ejemplo de Programa de Apoyo y Orientación

- Servicios de apoyo y orientación a la familia
- Planificación de visitas
- Coordinación de citas médicas
- Asistencia con tareas diarias

El equipo de apoyo y orientación está disponible para atender las necesidades específicas de cada familia. Los servicios de apoyo también pueden incluir la preparación de informes médicos y la comunicación con el equipo médico de atención de salud.

Si tiene alguna pregunta o necesidad de apoyo, por favor no dude en ponerse en contacto con nuestro equipo de apoyo y orientación.
Quality Improvement Workplan

MONTEREY COUNTY BEHAVIORAL HEALTH
FISCAL YEAR 2016/2017
QUALITY IMPROVEMENT WORK PLAN (2016-2017)

About Monterey County
Monterey County is one of 58 counties in the state of California. The United States Census reported the 2010 population to be estimated at 433,898. Covering 3,322 square miles, Monterey County is comprised of 12 incorporated cities, and is divided into the following regions: Monterey Peninsula (Monterey, Pacific Grove, Carmel-by-the-Sea, Carmel Valley, Seaside, Marina, Sand City, Del Rey Oaks and Pebble Beach); Big Sur; North County (Marina, Moss Landing, Prunedale and Castroville); and the Salinas Valley (Salinas, Soledad, Gonzales, Greenfield and King City). The economy is primarily based upon tourism and agriculture. The largest racial/ethnic group is Hispanic/Latino (57%) followed by White (31%). U.S. Census noted 20.3% of families with related children under 18 years of age lived in poverty (15.7% in 2010). The number of persons per household was 3.24 with a median household income of $58,582.

Salinas is the largest city in the county. 40% of adults living in the city of Salinas do not have a high school diploma or General Education Diploma (GED); 30% of adults have less than 9th grade education (U.S. Census Bureau, 2009-2011).

Monterey County Behavioral Health
Monterey County Behavioral Health (MCBH) is organized into three geographic regions: Salinas Valley, Coastal Region, and South County. All regions provide services to children, adults, and older adults. During Fiscal Year 2015-2016 MCBH provided services to 10,482 consumers. The number of consumers served during Fiscal Year 2014-2015 was 8,558.

Quality Management
Quality Management is a high priority in Monterey County. We value our community and the quality of service we provide. Quality Management is provided through a robust system comprised of multiple programs within our organization. Collectively, it is through these programs that we obtain information on quality of care, evaluation of current processes, and identification of areas for improvement. Through the use of data to inform decision, we are able to make the necessary changes to meet the needs of our community. Quality Management ensures to meet all state, federal, and local level regulatory requirements.

Quality Improvement Work Plan
The goals identified in this work plan speak to our continuous quality improvement efforts to identify and meet the mental health and substance use disorder treatment needs of our community. The goals described here are not intended to be all encompassing, but are important to our overarching quality improvement efforts for Fiscal Year 2016-2017 (July 2016-June 30, 2017).
Area of Focus: Monitoring/Improving Access to Services

**Goal 1**: Improve timely access to urgent appointments following an inpatient hospitalization and/or emergency department crisis evaluations (when warranted)

**Interventions 1a**: Develop a process to schedule and track urgent appointments  
**Measurement 1a**: Obtain baseline for urgent appointments (within 5-calendar days of request)  
**Evaluation 1a**: Appointments made available with 5-calendar days; review use of urgent appointments monthly  
**Baseline 1a**: establish baseline

**Intervention 1b**: Use of telemedicine to improve timeliness to service  
**Measurement 1b**: Decrease wait times to receive medication support services  
**Evaluation 1b**: Telemedicine available in all service regions and wait times are decreased  
**Baseline 1ba**: obtain baseline; develop tracking mechanism

**Intervention 1c**: Use of teletherapy to improve timeliness to service  
**Measurement 1c**: Pilot use of teletherapy in south county region  
**Evaluation 1c**: Evaluate effectiveness of teletherapy  
**Baseline 1c**: Teletherapy available in south county program

**Goal 2**: Decrease wait times for follow up appointment following inpatient hospital (MHU) discharge

**Interventions**: Use of direct referral process for allocation of an outpatient appointment by providing client/family with outpatient appointment prior to discharge from MHU  
**Measurement**: 10% increase from baseline (appointments within 7 days from discharge)  
**Evaluation**: Review data quarterly with leadership via QIC; identify trends and interventions to address concerns, when warranted  
**Baseline**: clients who received a follow up service 7 days following MHU discharge in FY 15/16  
- Adults-45%  
- Children-38%

**Goal 3**: Improve accessibility to care for determination of behavioral health needs.

**Intervention 3a**: Evaluate potential barriers to accessing care  
**Measurement 3a**: Develop one (1) strategy to address the identified barrier(s)  
**Evaluation 3a**: Increase number of individuals served  
**Baseline 3a**: FY 15/16—10,482 individuals received a mental health service
**Intervention 3b:** Test use of LOCUS-like tool for improved screening to more quickly get clients to appropriate levels of care

**Measurement 3b:** Assessment completed in shorter time frame; client was referred to appropriate level of care

**Evaluation 3b:** Evaluate the effectiveness of tool; evaluate time to completion of assessment

**Baseline 3b:** Obtain baseline

---

**Goal 4:** Increase number of clients served in Bienestar

**Interventions:** Continue to identify standards for transitions to appropriate level of care

**Measurement:** Increase number of clients referred to Bienestar and Integrated levels of care

**Evaluation:** Review data at least twice, yearly

**Baseline:** (FY 15/16) Bienestar: 591 served

---

**Goal 5:** Continue to work with Beacon and safety net providers to improve referral methodologies

**Interventions:** Continue use of tracking referrals to/from Beacon; Work toward development of a contract with Beacon

**Measurement:** Increase number of clients referred and offered services through Beacon

**Evaluation:** Development of a contract and methodologies for referrals; Review of follow up care by Beacon

**Baseline:** obtain baseline

---

**Goal 6:** Improve level of care with step down process

**Interventions:** Improve relationships with primary care to support step-down services and substance use disorder assessment and intervention. Develop policies/procedures regarding interface with primary care

**Measurement:** Improve coordination with primary care; step down clients from other levels of care

**Evaluation:** Strengthen relationships; development of policies to support work with primary care; continue integration of clinical staff in primary care clinics

**Baseline:** Psychiatrist, clinical supervisor, and clinical staff already placed in primary care; development of procedures
Goal 7: Monitor 24/7 Call Line

**Interventions:** Train staff members on customer support and proper use of call-log system

**Measurement:** Improve customer service, information sharing, and logging calls received (daytime calls); 95% of the calls will follow protocol

**Evaluation:** Ongoing test calls conducted by QI; QIC to review call-log data, quarterly

**Baseline:** 1/2016 – 4/2016 test calls logged: 0 of 7

---

Goal 8: Identify method to track and follow-up on urgent behavioral health conditions with 90% accuracy

**Interventions:** Evaluate and identify a tracking methodology; make changes in Avatar to meet this need; educate staff on process/procedure

**Measurement:** Method for tracking and following up will be established; all ACCESS staff to be trained on process/procedure

**Evaluation:** QI to evaluate and identify a method to capture urgent conditions; establish protocols for follow up; QI team to evaluate monthly for first 3 months, quarterly thereafter, if no concerns arise

**Baseline:** establish baseline

---

Goal 9: Improve behavioral health service delivery system

**Interventions:** Develop an improved methodology for authorization of services; small-scale testing methodology

**Measurement:** Evaluate effectiveness of authorization process

**Evaluation:** System-wide implementation of authorization program

**Baseline:** Obtain baseline

---

Goal 10: Improve timeliness to service delivery post assessment

**Interventions:** Evaluate current process; identify areas for enhancement; standardize referral process across the organization; train staff on standard process

**Measurement:** All programs will utilize standardized process for use of waitlist and referral

**Evaluation:** QI team to conduct utilization review, quarterly; bring forth concerns of wait list to leadership

**Baseline:** No current uniform process for using waitlist and referral exists
Area of Focus: Monitoring/Improving Delivery of Services and Capacity

Goal 1 Improve client’s goal attainment to move to lower levels of care

Interventions 1a: Identify current use of EBP and evaluate training needs to support fidelity to the models; develop a method for measuring effectiveness of EBP
Measurement 1a: Focus on two (2) EBPs; train staff on EBP; support fidelity to EBP model
Evaluation 1a: Clinical staff receive training and support for EBP; evaluate number of clients who moved to a lower level of care and received services using EBPs
Baseline 1a: FY 15/16: 27.28% of progress notes identified use of EBP (239,151 service totals)

Intervention 1b: Evaluate outcomes data to examine if EBPs were used in treatment to support goal attainment
Measurement 1b: Clients with met or partially met treatment goals received services using EBPs when compared to those who did not attain goals.
Evaluation 1b: Qualitative review of charts to examine data if clients with treatment goals met or partially met received EBPs as part of course of treatment when compared to those who did not meet treatment plan goals
Baseline 1b: FY 15/16 data
- Overall System of Care- 32%
- Access to Treatment- 27%
- Adult’s System- 13%
- Children’s System- 29%
- Substance Use Disorders- 29%

Goal 2: Increase understanding data for no-show rates for appointments for medication support in order to improve client engagement in treatment.

Interventions 2a: Enhance use of follow-up protocol for no-show appointments for medication support
Measurement 2a: System-wide use of follow-up protocols are followed
Evaluation 2a: Consistent use of follow-up protocols for no-shows across the system
Baseline 2a: Inconsistent use of follow-up protocols

Measure 2b: Monitor use of follow-up protocols
Evaluation 2b: Decrease in no-show rates for psychiatrists
Baseline 2b: CY 15 data—28% no-show rates for appointments with psychiatrists
**Goal 3:** Monitor compliance with CalOMS and DATAR submissions for substance use disorder (SUD) services delivery capacity

**Interventions:** Continue monthly monitoring of data submissions; provide CalOMS training; offer technical assistance

**Measurement:** 5% overall compliance rate among SUD providers

**Evaluation:** QIC review of data, quarterly

**Baseline:** FY15/16 DHCS data: overall SUD providers in our system had a 32.8% compliance rate

---

**Area of Focus: Crisis Intervention**

**Goal 1:** Decrease number of unnecessary emergency department (ED) Crisis Team visits (at Natividad Medical Center, NMC); increase number of clients who receive mobile crisis

**Interventions:** use of mobile crisis services to manage crisis event in community setting

**Measurement:** decrease number of unnecessary emergency department visits; increase mobile crisis services

**Evaluation:** QIC data evaluation, quarterly via mobile crisis report via Avatar

**Baseline:** FY 15/16

- Number of clients with ED Crisis Team visit: 1,437
- ED visit resulting in NMC inpatient admission: 933 clients (64.9%)

Mobile Crisis Team Services (all regions):

- 59 (16%) resulted in involuntary holds
- 29 (8%) received brief crisis intervention with significant support person
- 72 (20%) received a crisis intervention with client AND a referral to community services

---

**Goal 2:** Monitor and decrease inpatient hospital 7-day and 30-day readmissions rates

**Interventions:** Develop and use of urgent appointment to secure outpatient follow up appointment following a discharge from an inpatient hospital

**Measurement:** Decrease number of re-hospitalization within 7 and 30 days of discharge

**Evaluation:** Review data, quarterly using Avatar report

**Baseline:** FY 15/16

- Within 7-days from discharge: 437 (59%)
- Within 30-days from discharge: 82 (11%)
Goal 3: Increase understanding of crisis utilization service (MHU, ED Crisis, etc.) and identify strategies to address concerns

Interventions: Use of Harbage consultation for in-depth review and understanding of crisis utilization services
Measurement: Increased understanding of utilization and identification of strategies to address issues
Evaluation: determine based on report from Harbage Consultation
Baseline: FY 15/16

<table>
<thead>
<tr>
<th>Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clients received an ED crisis service</td>
<td>1,437</td>
</tr>
<tr>
<td>Number of clients who had 4+ ED crisis visits</td>
<td>285 (20%)</td>
</tr>
<tr>
<td>Number of clients admitted to inpatient psychiatric hospital</td>
<td>933</td>
</tr>
<tr>
<td>Number of clients re-hospitalized</td>
<td>228 (24%)</td>
</tr>
</tbody>
</table>

Area of Focus: Cultural and Linguistic Services

Goal 1: Improve cultural humility and sensitivity within service delivery

Interventions: Identify trainings that incorporate cultural relevance and sensitivity to service delivery
Measurement: Identify one (1) trainings and encourage staff participation
Evaluation: All behavioral health staff to participate in cultural sensitivity/humidity training on a yearly basis
Baseline: obtain baseline

Goal 2: Continue to work with Beacon and safety net providers to improve referral methodologies in South County region

Interventions: Work toward development of a contract with Beacon to meet community needs
Measurement: Contract obtained with Beacon
Evaluation: Development of a contract and methodologies for referrals
Baseline: D3 FY 15/16: no mental health providers are available in this region
Goal 3: Improve health equity in for Latino population

Interventions: Prioritize regions when hiring new staff; use of telehealth and telemedicine; maintain full time psychiatrists;
Measurement: QIC to evaluate, quarterly
Evaluation 3a: South County to see an increase in number of clients served by 1% using client served by region of residence data report in Avatar
Baseline 3a: D3 FY 15/16: Percent of clients served in this region was 15% (13% in FY 14/15)

Evaluation 3b: Review equity of service value using Breakdown of clients served by ethnicity
Baseline 3b: D3 FY 15/16—53% of Latinos received 49% of the overall service value

Area of Focus: Beneficiary Satisfaction

Goal 1: Evaluate client/family satisfaction with services

Interventions: Identify a user-friendly consumer satisfaction survey
Measurement: Selection and implement satisfaction survey; use of data to inform decisions
Evaluation: Use survey; QIC to evaluate survey information, at least annually
Baseline: obtain baseline

Goal 2: Continue to monitor and respond to grievances, appeals, expedited appeals, fair hearings, expedited fail hearing, provider appeals, and changes of clinician forms

Interventions: QI staff to address client concerns and adhere to problem resolution process;
Measurement: Respond to client concerns in accordance with problem resolution process, 100% of the time
Evaluation: Review trends in QIC, at least annually
Baseline: 99% all calls are logged and all processes are followed

Goal 3: Verify of services delivery by clients/family

Interventions: Develop method for service verification and implement process
Measurement: Attempt to verify 1% of the face-to-face, outpatient (non-crisis intervention) services delivered during fiscal year
Evaluation: Take necessary actions, as indicated; Discuss trends in QIC, annually
Baseline: Prior method of collection yielded 11.5% of the 277 calls attempted
Area of Focus: Electronic Health Record (EHR)-Avatar

Goal 1: Ensure EHR is well maintained and accessible to all users

**Interventions:** Monitor system performance, promptly address issue to eliminate downtime
**Measurement:** 99% online time for Avatar system
**Evaluation:** ongoing evaluation and monitoring
**Baseline:** 99% online time

Goal 2: Implement Meaning Use stage 2 requirements and/or continue use of best-practice standards of care

**Interventions:** Implement components for Meaningful Use and attest stage 2
**Measurement:** Obtain compliance with stage 2 via attestation and/or clear best-practice methodologies related to client care
**Evaluation:** Attestation of meaning use stage 2; identify components that support meaningful client care (Continuity of Care Document and My Health Point, client portals)
**Baseline:** use of best-practice model of care

Goal 3: HIPAA compliant data sharing across providers

**Interventions:** Continue exploration of methods for data sharing across providers; Participation in data sharing workgroups/committees to identify an electronic master patient index solution (eMPI)
**Measurement/Evaluation:** Identification of eMPI process
**Baseline:** Multiple barriers: Restrictions related to confidentiality laws and lack of interoperability among different systems
Area of Focus: Quality Improvement Committee (QIC)

Goal 1: Ensure policies are congruent with business practices for mental health and substance use disorder services

Interventions: Facilitate monthly QIC meetings; update policies/recommend policy decisions/update policies to meet needs of client population and congruency with business practices
Measurement: 10-12 monthly meetings per calendar year; QIC comprised of staff, community partners, clients, and advocates; policies are congruent with client care and business practices
Evaluation: Minutes place on QI website and reflect policy changes/updates
Baseline: CY15: Total of 7 QIC meeting held

Goal 2: Incorporate QI activities related to substance use disorder (SUD) 1115 Drug MediCal special terms and conditions.

Interventions: Develop and review policies for implementation of SUD service delivery; review of other QI activities in accordance with 1115 Waiver implementation, including, but not limited to reviewing information on problem resolution
Measurement: Present and approve policies related to SUD services; Review of data related to, but not limited to, timely access of services, initial contact, frequency of follow-up, and problem resolution process.
Evaluation: QIC to review and provide feedback on ongoing basis (QIC to facilitate 10-12 monthly meetings)
Baseline: none. To me incorporated (implementation plan approved by DHCS in 11/2016)

Goal 3: Continue to educate on Compliance Plan and obtain attestations from all staff

Intervention: Incorporate Compliance Plan attestation in onboarding process for new-hires through the training academy; Review compliance by existing staff members
Measurement: 100% of staff who submit claims to DHCS will sign attestation; utilize report available in Avatar
Evaluation: Monitor attestation by new and existing staff members
Baseline: Obtain baseline; many were signed on paper and will need to be collected for tracking purposes.
Area of Focus: Utilization Management/Quality Improvement

Goal 1: Continue ongoing evaluation for medical necessity/appropriateness for level of care/efficiencies

Interventions 1a: Review 100% of mental health and substance use disorder services (SUD) programs
Measurement 1a: All programs reviewed at least annually
Evaluation 1a: QI team review mental health and SUD programs using clinical utilization review tool; finding, recommendations, and plan of corrections will be directly discussed with program managers/supervisors
Baseline 1a: FY15/16
Mental Health Programs reviewed 85%
SUD Programs reviewed 100%

Interventions 1b: Develop process for clinical supervision to support medical necessity criteria is met
Measurement 1b: Revamp UR tool to more accurately reflect clinical need and assessment of medical necessity criteria to be used by Supervisors/Mangers
Evaluation 1b: QI team will review “clinical UR tool” monthly for first 3 month of implementation; QI to review quarterly, thereafter, using report in Avatar. Mangers to review quarterly via report in Avatar
Baseline 1b: Obtain baseline pending development of tool; QI team to review clinical UR completed by Supervisors/Managers, quarterly via Avatar report and report back

Goal 2: Continue to monitor medication practices

Interventions: MD consultant to review documentation and report back to QI and Medical Directors; MD and QI to provide training as necessary
Measurement: Practices meet prescribing standards
Evaluation: review 10% sample of each MD charts on a yearly basis
Baseline: FY15/16: 10% of every MD chart were reviewed
**Goal 3**: Continue monitoring and evaluation for documentation of medical necessity, appropriateness of services, and quality of care on an ongoing basis

**Intervention 3a**: Boost utilization review process to include more comprehensive understanding and targeted feedback, including informing training needs to training program

**Measurement 3a**: Continue evaluation and monitoring of services by QI

**Evaluation 3a**: 10% review of charts, annually

**Baseline 3a**: FY 15/16: 8% charts were reviewed

**Intervention 3b**: Enhance clinical review tool to support clinical supervision and ensure medical necessity is met

**Measurement 3b**: Develop and implement use of clinical UR tool; Improved quality of service delivery; continue to ensure charts meet medical necessity; increase the number of charts/progress notes that meet compliance for claiming

**Evaluation 3b**: Each supervisor will utilize enhanced clinical review tool with supervisee to review charts weekly; QI team will review effectiveness of tool and report back, monthly for 3 months, quarterly, thereafter.

**Baseline 3b**: obtain baseline

---

**Goal 4**: Increase compliance with 72-hour documentation of services standard to support ongoing communication with other staff regarding client’s treatment

**Interventions**: Monthly compliance review by supervisors via EHR report; QI will continue to review compliance and provide staff/supervisor feedback, as necessary

**Measurement**: 85% of progress notes will meet timeliness requirement

**Evaluation**: QI to continue monitoring via UR process to support increase of compliance

**Baseline**: FY 15/16: 78.82% of all progress notes met timeliness requirement

---

**Goal 5**: Support client care when treatment team determines need for collaborative process to address client concerns, including high-risk situations

**Interventions**: Facilitate Collaborative Case Conferences (CCC) to meet client needs

**Measurement**: QI to continue to make CCC available to all staff and providers and facilitate process

**Evaluation**: QI to report back to leadership, as appropriate, and make recommendations for system changes, when applicable

**Baseline**: FY 14/15: total of 10; FY 15/16: total of 7
Goal 6: QI to continue ongoing communication, support, and provide resources for staff and contracted partners

Interventions 6a: Update/refine Clinical Documentation Guide at least annually
Measurement 6a: Updated Clinical Documentation Guide will accurately reflect changing business practices
Evaluation 6a: Updated documentation guide posted to QI website
Baseline 6a: Update at least annually

Interventions 6b: Continue communication via QI monthly newsletter
Measurement 6b: Sustain communication with staff
Evaluation 6b: Monthly newsletter is electronically sent to all staff and providers and made available on the QI website, monthly
Baseline 6b: FY 15/16—11 monthly newsletters were developed and distributed

Interventions 6c: Continue to update QI website content to ensure most up-to-date information is available
Measurement 6c: Ongoing evaluation and updating of content
Evaluation 6c: Sustain communication with staff; content is accurate and up-to-date
Baseline 6c: Updated content as necessary

Interventions 6d: Improve communication between QI team and staff/contracted partners to incorporate staff input in projects and system changes
Measurement 6d: Increase QI participation staff meetings; provide information of upcoming changes and performance improvement efforts; receive and evaluate feedback; incorporate feedback into change process, when appropriate
Evaluation 6d: Regular participation in supervisor/manager meetings and participate in program team meetings as requested
Baseline 6d: QI currently participates in program team meetings and supervisor/manager meetings when requested
PROPOSED MHSA PROGRAM EVALUATION STRUCTURE

1. Is this part of the MHSA Mandate?

Prevention and Early Intervention (PEI)
5=One of the required PEI programs and implementing the three PEI strategies (see below).
4=One of the required PEI programs and implementing two of the three PEI strategies.
3=One of the required PEI programs and implementing one of the three PEI strategies.
2= Not one of the required PEI programs and not implementing any of the three PEI strategies.
1= Not a mental health program.

Community Services and Supports (CSS)
5= High Functioning Full Service Partnership (FSP), essential part of providing care to FSP priority populations, and applies the six guiding principles for system transformation.
4= Moderately Functioning FSP, essential part of providing care to FSP priority populations, and applies the at least four of the guiding principles for system transformation.
3= Non-FSP, essential part of providing care to priority populations, and applies at least three of the guiding principles for system transformation.
2= Non FSP, essential part of providing care to priority populations, and applies less than three of the guiding principles for system transformation.
1= Does not provide care to priority populations, and does not apply the guiding principles for system transformation.

Required PEI Strategies:
1) Be designed and implemented to help create access and linkage to treatment to children, youth, adults, and seniors with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to care provided by county mental health programs.
2) Be designed, implemented, and promoted in ways that improve timely access to appropriate services for underserved populations through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services.
3) Be designed, implemented, and promoted using strategies that are non-stigmatizing and non-discriminatory (PEI Regulations).

Required PEI Programs:
1) “Access and Linkage to Treatment Program” means connecting children, youth, adults, and seniors with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to care provided by county mental health programs.
2) “Early Intervention Program” means treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes that may result from untreated mental illness.
3) “Outreach for Increasing Recognition of Early signs of Mental Illness Program” is a process of engaging, encouraging, educating, and/or training, and learning from potential responders about ways to recognize and respond effectively to early signs or potentially severe and disabling mental illness.
4) “Prevention program” means set of related activities to reduce the risk of developing a potentially serious mental illness and to build protective factors and reduce risk factors.
5) “Stigma and Discrimination Reduction Program” means the County’s direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families (PEI Regulations).
Required CSS Component service categories:

(1) Full Service Partnership. (a) The County shall develop and operate programs to provide services under the Full Service Partnership Service Category. “Full Service Partnership” means the collaborative relationship between the County and the client, and when appropriate the client’s family, through which the County plans for and provides the full spectrum of community services so that the client can achieve the identified goals.

(2) General System Development. (a) Improve the county mental health service delivery system for all clients and their families and/or to pay for specified mental health services and supports for clients, and/or when appropriate their families. The six guiding principles for system transformation are: 1) family and consumer driven, 2) Accessible and Timely, 3) Focused on Wellness and Recovery, 4) Culturally and Linguistically Competent, 5) Strength and Resiliency, 6) Integrated and Coordinated Services.

(3) Outreach and Engagement. The County shall conduct outreach to provide equal opportunities for peers who share the diverse racial/ethnic, cultural, and linguistic characteristics of the individuals/clients served. (a) Outreach and Engagement funds may be used to pay for: (1) Strategies to reduce ethnic/racial disparities. (2) Food, clothing, and shelter, but only when the purpose is to engage unserved individuals, and when appropriate their families, in the mental health system. (3) Outreach to entities such as community based organizations, schools, and other sectors.

Required Eligibility Criteria for the “Full Service Partnership” Service Category

Clients with severe mental illness who are underserved or unserved and at risk of one of the following:
(A) Homelessness or at risk of being homeless.
(B) Institutionalization.
(C) Nursing home or out-of-home care.
(D) Frequent users of hospital and/or emergency room services as the primary resource for mental health treatment.
(E) Involvement in the criminal justice system or foster care system.

2. Does this program have a high clinical impact?

The program components are successfully implemented utilizing evidence-based practice standards and consistently show improved mental health outcomes for the intended population (PEI Regulations).

3=Program consistently shows improved mental health outcomes for the intended population
2=Program is starting or planning to track strong quantitative and qualitative data showing positive outcomes
1=Program does not measure mental health outcomes

3. Is this program part of addressing regional health inequity?

5=South County
4=>30% South County
3=Salinas & North County
2=Salinas & Peninsula
1=Peninsula

South Monterey County continues to be underserved. 20% of the Medi-Cal population lives in South County. However, only 13% of individuals receiving therapeutic services from Monterey County Behavioral Health (MCBH) reside in South County. 7% of individuals served by Alcohol and Other Drug Prevention and Treatment services were from South County. Services provided by contracted providers follow the same trend (MCBH Strategic Plan, pg.7).
4. **Is this program part of increasing services to the Latino population?**

5=80-100% of clients are Latino  
4=60-80% of clients are Latino  
3=40-60% of clients are Latino  
2=20-40% of clients are Latino  
1=0-20% of clients are Latino

MCBH is committed to reducing health inequities by increasing services to the Latino Population. 78% of Medi-Cal eligible in Monterey County are Latino; however, only 32% of individuals served by the Adult System of Care are Latino (MCBH Strategic Plan, pg.7).

5. **Is this program leveraging other resources (maximizing community impact with MHSA dollars)?**

3=Leveraging 71-100%  
2=Leveraging 50-70%  
1=Leveraging <50%

The program is using additional funding and resources to maximize its community impact. For example, some MHSA funded programs are leveraging funds from Medi-Cal. Rating: (High=3, Moderate =2; Low=1)

6. **Is this program cost effective?**

Cost effectiveness is the degree to which a program is effective or productive in relation to its cost. For example, in 2015 dollars, CalMHSA’s annual investment costs in ASIST averaged just over $350,000. The RAND Corporation estimated that one year of CalMHSA’s investment in ASIST may help to avert 3,569 suicide attempts over the next 28 years, of which approximately 143 would have been fatal and 581 would have been otherwise incapacitating (Analysis of the Benefits and Costs of CalMHSA’s Investment in Applied Suicide Intervention Skills Training (ASIST) by Ashwood, et al).

7. **What is the level of contract performance?**

3=High  
2=Moderate  
1=Low

8. **Could the program be funded by other sources?**

3=no  
2=maybe  
1=yes

The program can be funded with non-Mental Health Services Act funding. For example, school based mental health programs could be funded, at least in part, with the Local Control Funding Formula (LCFF). The LCFF requires school districts to involve parents in planning and decision-making as well as in developing Local Control and Accountability Plans (LCAPs).