THE BOARD OF SUPERVISORS OF THE COUNTY OF STANISLAUS
BOARD ACTION SUMMARY

DEPT: Behavioral Health & Recovery Services

BOARD AGENDA:7.1
AGENDA DATE: June 10, 2025

SUBJECT:
Approval to Adopt the Mental Health Services Act (MHSA) Annual Update for Fiscal Year 2025-2026 and Three Year Prevention Early Intervention Evaluation Report for Fiscal Years 2021-2022, 2022-2023, and 2023-2024; and Related Actions

BOARD ACTION AS FOLLOWS: **RESOLUTION NO. 2025-0333**

On motion of Supervisor Withrow **Seconded by Supervisor** Grewal
and approved by the following vote,
Ayes: Supervisors: Chiesa, Withrow, Grewal, C. Condit, and Chairman B. Condit
Noes: Supervisors: None
Excused or Absent: Supervisors: None
Abstaining: Supervisor: None

1) X **Approved as recommended**
2) _____ **Denied**
3) _____ **Approved as amended**
4) _____ **Other:**

MOTION:

Kelly Rodriguez

ATTEST: KELLY RODRIGUEZ, Assistant Clerk of the Board of Supervisors

File No.

THE BOARD OF SUPERVISORS OF THE COUNTY OF STANISLAUS
AGENDA ITEM

DEPT: Behavioral Health & Recovery Services BOARD AGENDA:7.1
AGENDA DATE: June 10, 2025

CONSENT ☐

CEO CONCURRENCE: YES 4/5 Vote Required: No

SUBJECT:

Approval to Adopt the Mental Health Services Act (MHSA) Annual Update for Fiscal Year 2025-2026 and Three Year Prevention Early Intervention Evaluation Report for Fiscal Years 2021-2022, 2022-2023, and 2023-2024; and Related Actions

STAFF RECOMMENDATION:

1. Adopt the Mental Health Services Act (MHSA) Annual Update for Fiscal Year 2025-2026 and report actual results for Fiscal Year 2023-2024 and allow the expenditure of MHSA Funds for the services referenced in the Annual Update.
2. Authorize the Behavioral Health Director or designee to sign and submit the MHSA Annual Update for Fiscal Year 2025-2026 to the Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission.
3. Authorize the Auditor-Controller, or designee, to sign the Mental Health Services Act County Fiscal Accountability certifying that the fiscal requirements have been met.
4. Adopt the Mental Health Services Act Prevention and Early Intervention (PEI) Three-Year Evaluation Report for Fiscal Years 2021-2022, 2022-2023, and 2023-2024.

DISCUSSION:

As the contracted Behavioral Health Plan (BHP) with the State of California, Behavioral Health and Recovery Services (BHRS) administers Stanislaus County's behavioral health services, providing integrated mental health services to adults and older adults with a serious mental illness (SMI) and to children and youth with a serious emotional disturbance (SED). BHRS also provides substance use disorder (SUD) services for adults and adolescents, supportive services, prevention and early intervention services, and serves as Stanislaus County’s Public Guardian.

Proposition 63, otherwise known as the Mental Health Services Act (MHSA), created a 1% tax on income more than $1 million to expand mental health services. It was designed to expand and transform California's behavioral health system to better serve individuals with, and at risk of, serious mental health issues and their families. MHSA addresses a broad continuum of prevention, early intervention, and service needs and the necessary infrastructure, technology, and training elements that support the public behavioral health system.

As required by Welfare and Institutions Code Section 5892(a) and State guidelines, counties must allocate and expend funds as follows:

- Innovations: 5%
- Prevention & Early Intervention (PEI): 19%
- Community Services & Supports (CSS): 76%

To expend funds, the County must:

- Prepare a Three-Year Program and Expenditure Plan.
- Gain approval of the plan through an annual stakeholder process.
- Spend in accordance with an approved plan.
- Prepare and submit MHSA Annual Revenue and Expenditure Reports (RER)

MHSA funding is not tied to demand for services, is not guaranteed, and revenue can be volatile. Behavioral Health and Recovery Services (BHRS) administers Stanislaus County's behavioral health services and uses MHSA funding to provide integrated mental health and supportive services to adults and older adults with a serious mental illness (SMI) and to children and youth with a serious emotional disturbance (SED). BHRS also uses funding to strengthen prevention and early intervention efforts and to build a “help first” system of care to eliminate disparities and promote wellness, recovery, and resiliency outcomes.

Fiscal Year 2025-2026 Program and Expenditure Plan

Stanislaus County BHRS is presenting the MHSA Annual Update for Fiscal Year 2025 - 2026. This Annual Update reflects MHSA programs and activities from July 1, 2023, to June 30, 2024. The Annual Update will serve the following purposes:

- Outline programmatic changes that are being recommended, that, if approved, will become effective in Fiscal Year 2025-2026. Details of the recommended changes can be found on pages 18-19.
- Update the Three-Year Program and Expenditure Plan (PEP) for Fiscal Year 2025-2026 as required by 9 CCR § 3310. The updated funding table and individual component worksheets can be found on pages 24-32.
- Report actual results for programs and services that were funded by MHSA in Fiscal Year 2023-2024 as required by MHSA Statute (W&I Code §5847). Information can be found on pages 33-186.

This Annual Update is developed with feedback from the MHSA Advisory Committee. Information about the Community Program Planning Process can be found on pages 187 -192 of this document.

For Fiscal Year (FY) 2025–2026, Stanislaus County anticipates receiving approximately 1.3% of statewide Mental Health Services Act (MHSA) revenue, with projected new funding and interest earnings totaling approximately $36.9 million. These funds will be allocated as follows: $27.9 million to Community Services and Supports (CSS), $7.0 million to Prevention and Early Intervention (PEI), and $2.0 million to Innovation (INN).

The substantive changes proposed in the MHSA update for FY 2025–2026 are:

- Redirecting approximately $12 million in Adult Residential Facilities contracts from CSS to the primary Behavioral Health and Recovery Services (BHRS) Budget Unit.
- Reducing transfers from CSS to the Capital Facilities and Technological Needs (CFTN) component.
- Reallocating $1 million for the Electronic Health Record contract from CFTN to the primary BHRS Budget Unit, spread over two fiscal years.
- While BHRS continues to assess the programmatic and fiscal impacts of the new Behavioral Health Services Act (BHSA), explained in some detail later in this report, across all MHSA components—including PEI, INN, Workforce Education and Training, CFTN, and Housing—no changes to service levels are currently recommended.

These adjustments are intended to address funding shortfalls caused by recent volatility and declines in MHSA revenues. The BHSA planning process is expected to align future MHSA expenditures with the County's annual allocation.

Three-Year Prevention & Early Intervention Evaluation Report

Prevention and Early Intervention (PEI) programs strive to lower the likelihood of serious mental health conditions by offering timely support to underserved communities. Stanislaus County Behavioral Health Services (BHRS) assesses these programs every three years and shares its findings. This current evaluation covers fiscal years 2021-2022, 2022-2023, and 2023-2024. The resulting report details PEI program types, strategies used, data sources, challenges encountered, strengths identified, and suggestions for future enhancements. This evaluation aims to determine how well these programs improve accessibility, engagement, and overall community mental health. As part of the Three-Year Program and Expenditure Plan or Annual Update, this report is submitted to the Behavioral Health Services Oversight and Accountability Commission every three years. Ultimately, the Three-Year Prevention and Early Intervention Evaluation Report addresses the impact of PEI programs on individuals at risk of or experiencing early signs of serious mental illness, as well as their effects on mental health and related support systems.

Due to the Behavioral Health Services Act (BHSA) structural changes, this will be the last prevention report. Prevention funding has been restructured from county initiatives to statewide prevention initiatives. The state now retains 10% of BHSA funds, with 4% for statewide prevention programs, 3% for workforce development, and 3% for administration. Of the 90% of BHSA funds received by counties, 30% will be allocated to Housing Interventions, 35% to Full-Service Partnerships, and 35% to Behavioral Health Services and Supports.

Public Comment Period

The draft Annual Update was posted for a 30-day Public Review on April 22, 2025. Notification of the public review dates and access to copies of the draft Annual Update were made available through the following methods:

- An electronic copy of the Annual Update was posted on the County's MHSA website: www.stanislausmhsa.com.

- Paper copies of the Annual Update were delivered to Stanislaus County Public Libraries.
- Electronic notification was sent to all BHRS service sites with a link to www.stanislausmhsa.com, announcing the posting of the Annual Update.
- MHSA Advisory Committee, Behavioral Health Board members, and community stakeholders received the Public Notice about the 30-day review and how to obtain a copy of the Annual Update.
- Public Notices were published in newspapers across Stanislaus County. These notices provided access to the Annual Update online at www.stanislausmhsa.com and included a phone number requesting a copy of the document.

A public hearing by the Stanislaus County Behavioral Health Board was held at the Stanislaus County Veterans Center, 3500 Coffee Rd, Suite 15, Modesto, CA, on May 22, 2025, at 5 p.m., concluding the public comment period.

The three-year PEI report is not subject to a public comment period.

Strategic Initiatives

BHRS Leadership continues to develop the behavioral health continuum of care, implement local impacts of California's Advancing and Innovating Medi-Cal (CalAIM) initiatives, and make strategic investments to build capacity in the Core Treatment Model (CTM) and administrative infrastructure and capabilities.

The MHSA Program and Expenditure Plan for Fiscal Year 2025-2026 is recommended to align with existing Strategic Initiatives, and where additional funding has been identified, deepen the Department's commitment to the provision of quality behavioral health treatment and supports to the community by dedicated behavioral health workers and partnerships with community-based organizations. These investments will continue to increase the capacity of the Department's core treatment services to meet the needs of the Stanislaus County Medi-Cal beneficiaries and priority underserved and unserved populations.

BHRS will continue its focus on several Strategic Initiatives for Fiscal Year 2025-2026:

- CalAIM
- One-stop shop for a supportive services facility project
- Supportive services
- Innovation
- Workforce development and training
- Building administrative infrastructure and capabilities

Behavioral Health Transformation: Introducing the Behavioral Health Services Act

In March 2024, California voters passed Proposition 1, a two-bill package to modernize the state's behavioral health care system, improve accountability and increase transparency, and expand the capacity of behavioral health care facilities. The efforts to implement Proposition 1, including the Behavioral Health Services Act (BHSA), are referred to as Behavioral Health Transformation (BHT). The BHT is a policy manual where counties, providers, and other behavioral health stakeholders will find information on county planning, reporting, and fiscal requirements on BHSA.

The Behavioral Health Services Act, Senate Bill 326:

- Reforms behavioral health care funding to provide services to individuals with serious mental illness and treat substance use disorders.
- Expands the behavioral health workforce to reflect and connect with California's diverse population.
- Focuses on outcomes, accountability, and equity.

The Behavioral Health Infrastructure Bond Act of 2024 (BHIBA) AB 531:

- Funds behavioral health treatment beds, supportive housing, and community sites through the Department of Health Care Services (DHCS).
- Directs funding for housing for veterans with behavioral health needs through the Department of Housing and Community Development (HCD).

BHSA further replaces the Mental Health Services Act (MHSA) 2004, effective January 1, 2025.

The reforms within the BHSA expand and increase the types of behavioral health support available to Californians in need by focusing on historical gaps and emerging policy priorities.

The key opportunities for transformational change within the BHSA include:

- Reaching and serving high-need priority populations.
- Increasing access to substance use disorder treatments.
- Increasing access to housing interventions with a focus on serving the chronically homeless residing in encampments.
- Increasing access to evidence-based practices and community-defined practices.
- Building the behavioral health workforce.
- Focusing on outcomes, transparency, accountability, and equity.

The BHSA is the first major structural reform of the MHSA since it was passed in 2004. A crucial transformation under the BHSA pertains to the funding structure. The BHSA eliminates the five existing MHSA funding components, including the prevention component, and introduces a new housing component. Under the BHSA, counties are mandated to allocate funds as follows:

- 35 percent of funds for Full-Service Partnership.
- 35 percent of funds for Behavioral Health Services and Supports.
- 30 percent of funds for Housing Interventions.

Effective January 1, 2025, counties must engage the local stakeholders to develop each element of an Integrated Plan. With the revised community planning process, counties are required to demonstrate a partnership with constituents and stakeholders throughout the process, which includes meaningful stakeholder involvement in behavioral health policy, program planning and implementation, monitoring, workforce development, quality improvement, evaluation, health equity, and budget allocations. Meaningful stakeholder engagement requires that counties conduct a community planning process that is open to all interested stakeholders and that stakeholders have opportunities to provide feedback on key planning decisions.

Stanislaus County BHRS has been working with the collective California counties through the California Behavioral Health Directors Association (CBHDA) and Department of Healthcare Services (DHCS) to understand the scope of BHSA legislation and help define, clarify, and shape BHSA policy and implementation guidance.

Stanislaus County actively participates in DHCS BHSA Workgroups, CBHDA BHSA Workgroups, and internal BHRS BHSA workgroups to ensure the Department is actively engaging, advocating, and aligning programs and services with the needs of the community served and the goals of BHSA.

New BHSA Reporting Requirements

The BHSA requires counties to submit a three-year Integrated Plan and an annual Behavioral Health Outcomes, Accountability, and Transparency Report (Plans) for behavioral health services and outcomes, aligning with statewide behavioral health goals established by the Department of Health Care Services (DHCS). Whereas the 3-Year Program and Expenditure Plan and Annual Update required under the MHSA focused exclusively on MHSA funding, the BHSA establishes the Plans to serve as a global spending plan that describes how county behavioral health departments plan to use all available behavioral health funding, including BHSA, 1991 and 2011 Realignment, federal block grant programs, Substance Use Prevention, Treatment, Recovery Services Block Grant (SUBG), federal financial participation from Medi-Cal, opioid settlement funds, any other federal, state, or local funding directed towards county behavioral health department services, and other funding to meet statewide and local outcome measures, reduce disparities, and address the unmet need in their community. The County Board of Supervisors must certify within each plan that the County is meeting its realignment obligations.

In accordance with the BHSA, the Plan provides a description of how counties plan expenditures across a range of behavioral health funding sources and deliver high-quality, culturally responsive, and timely care along the Behavioral Health Care Continuum for the plan period.

Fiscal Year 2024 Actual Results

The actual results for programs and services that MHSA funded in Fiscal Year 2023-2024 are shown on pages 33-186 of the attached Annual Update**.**

POLICY ISSUE:

Welfare and Institutions Code, Section 5847 (a), requires Counties to prepare and submit a Three-Year Program and Expenditure Plan (Plan) and Annual Updates (Update), adopted by the County's Board of Supervisors, to the MHSOAC and the Department of Health Care Services within 30 days of adoption. All expenditures of MHSA funds for mental health programs in a County must be consistent with a currently approved Plan or Update, as mandated by Welfare and Institutions Code, Section 5892(g).

All Plans and Updates are required to include a (1) certification by the County Mental Health Director to ensure County compliance with pertinent regulations, laws, and the status of the Mental Health Services Act, including stakeholder engagement and non-supplantation requirements (Welfare and Institutions Code, Section 5847 (b)(8)); and (2)

certification by the County Mental Health Director and the County Auditor-Controller that the County has complied with all fiscal accountability requirements and that all expenditures are consistent with the Mental Health Services Act (Welfare and Institutions Code, Section 5847 (b)(9)).

California Code of Regulations. Title. 9, § 3560.020 requires counties to submit a Three-Year Prevention and Early Intervention Evaluation Report to the Mental Health Services Oversight and Accountability Commission every three years as part of a Three-Year Program and Expenditure Plan or Annual Update. The Three-Year Prevention and Early Intervention Evaluation Report answers questions about the impacts of Prevention and Early Intervention Component Programs on individuals with risk or early onset of serious mental illness and on the mental health and related systems.

This Evaluation Report is in fulfillment of the requirements in Section 3560.020, 3560.010(b), and 3750 of the Prevention and Early Intervention Regulations.

FISCAL IMPACT:

The programs and expenditures described in the Annual Update are funded with MHSA funding, which leverages Medi-Cal Federal Financial Participation and several other funding streams to maximize services provided to the community. The BHRS 2026 Proposed Budget includes estimated revenue and appropriations to support the MHSA Fiscal Year 2025-2026 Program and Expenditure Plan. There is no impact to the County General Fund associated with the approval of this agenda item.

BOARD OF SUPERVISORS' PRIORITY:

The recommended actions are consistent with the Board of Supervisors' priorities of *Supporting a Healthy Community* by providing mental health and substance use disorder services in the community through vendor partnerships.

STAFFING IMPACT:

The continuation of services described in the attached Annual Update will be facilitated by existing BHRS staffing and resources.

CONTACT PERSON:

Ruben Imperial, Director (209) 525-6222
Behavioral Health and Recovery Services

ATTACHMENT(S):

1. MHSA FY 2025-26 Annual Update
2. PEI 3 Year Evaluation

STANISLAUS COUNTY
MENTAL HEALTH SERVICES ACT
ANNUAL UPDATE FOR FY 2025-2026

Behavioral Health and Recovery Services

WELLNESS • RECOVERY • RESILIENCE

Contents

COUNTY COMPLIANCE CERTIFICATION

County: Stanislaus

County Behavioral Health Director	Project Lead
Name: Ruben Imperial Telephone Number: 209-525-6225 E-mail: rimperial@stanbhrs.org	Name: Maribel McCarroll Telephone Number: 209-525-6247 E-mail: Mmccarroll@stanbhrs.org
Mailing Address: Stanislaus County Behavioral Health and Recovery Services 1601 I Street, Suite 200, 2nd Floor Modesto, CA 95354	

I hereby certify that I am the official responsible for the administration of county behavioral health services in and for said county and that the county has complied with all pertinent regulations, laws and statutes for this annual update/plan update. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

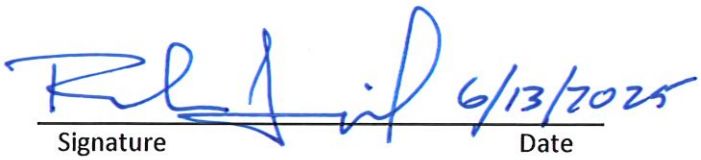
This Annual Update has been developed with the participation of stakeholders, in accordance with Title 9 of the California Code of Regulations section 3300, Community Planning Process. The FY 2023-2024 Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for public review and comment. All input has been considered with adjustments made, as appropriate.

A.B. 100 (Committee on Budget – 2011) significantly amended the Mental Health Services Act to streamline the approval processes of programs developed. Among other changes, A.B. 100 deleted the requirement that the three-year plan and updates be approved by the Department of Mental Health after review and comment by the Behavioral Health Services Oversight and Accountability Commission. Considering this change, the goal of this update is to provide stakeholders with meaningful information about the status of local programs and expenditures.

A.B. 1467 (Committee on Budget – 2012) significantly amended the Mental Health Services Act which requires three-year plans and Annual Updates to be adopted by the County Board of Supervisors; requires the Board of Supervisors to authorize the Behavioral Health Director to submit the annual Plan Update to the Behavioral Health Services Oversight and Accountability Commission (BHSOAC); and requires the Board of Supervisors to authorize the Auditor-Controller to certify that the county has complied with any fiscal accountability requirements and that all expenditures are consistent with the requirements of the Mental Health Services Act.

The information provided for each work plan is true and correct.

Ruben Imperial
Behavioral Health Director/Designee (PRINT)



Signature

6/13/2025
Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Stanislaus ☐ Three-Year Program and Expenditure Plan

☒ Annual Update

☐ Annual Revenue and Expenditure Report

Local Behavioral Health Director	County Auditor-Controller
Name: Ruben Imperial Telephone Number: (209) 525-6225 E-mail: rimperial@stanbhrs.org	Name: Mandip Dhillon Telephone Number: (209) 525 7507 E-mail: mdhillon@stancounty.com
Local Behavioral Health Mailing Address: 1601 I Street, Suite 200, 2nd Floor Modesto, CA 95354	

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

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

Ruben Imperial
Local Behavioral Health Director

Signature 6/13/2025
Date

I hereby certify that for the FY ended June 30, 2023, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated for the FY ended June 30, 2023. I further certify that for the FY ended June 30, 2023, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a). in that local MHSA funds may not be loaned to a county general fund or any other county fund.

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

Mandip Dhillon
County Auditor Controller / City Financial Officer

Signature Mandip Dhillon 06/23/25
Date

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

Message from the Director

The Mental Health Services Act (MHSA) Annual Update for FYs 2025-2026 is an opportunity for Stanislaus County Behavioral Health and Recovery Services (BHRS) to inform the community of highlights, accomplishments, and changes since its last Three-Year Plan. This year's Annual Update highlights MHSA activities from FY 2023-2024 and reflects our ongoing commitment to improve the Stanislaus County behavioral health system and create recovery driven programs and services. We couldn't do this work alone.

FY 2023-2024 marked the start of the new Three-Year Plan, which was guided by the many heartfelt community voices that participated in the Community Program Planning (CPP) process. Stanislaus BHRS continues to embrace the principles of MHSA and hold true to its values and BHRS leadership, staff, and partners continue to improve community collaboration, cultural and linguistic competence, access and linkage to services, and consumer-driven and family-driven decision making.

As the Director of Stanislaus County BHRS, I am excited about this Annual Update as well as the opportunity to continue to engage with consumers and family members, local stakeholders, community-based organization, County partners, public systems, oversight agencies, the Behavioral Health Board, and the community at large. Continued engagement will assist BHRS in serving the most vulnerable communities utilizing a culturally and ethnically diverse lens and continues to strive to address existing gaps and to improve timely and effective care through ongoing evaluation, process improvement, and data-informed decision making.

This Annual update continues to show alignment of MHSA with the BHRS Strategic Plan, approved by the Board of Supervisors on March 30, 2021 (Resolution No. 2021-0136). The Strategic Plan aligned program operations and services with sustainable funding to prioritize behavioral health treatment services to maximize the number of members served and leverage federal and state funding, maintain compliance with network adequacy standards, and create efficiencies by standardizing team structures and consolidating administrative structures. Since approval of the Strategic Plan, BHRS has focused on several Strategic Initiatives, including:

- Supporting ongoing recruitment efforts
- Expanding clinical training and program and staff development
- Partnering with school districts, colleges, and universities to develop a workforce pipeline
- Expanding residential treatment
- Increasing outpatient capacity for children and adults
- Managing caseloads
- Decreasing assessment wait times
- Increasing housing support services for members that are experiencing homelessness
- Developing a BHRS Fund Balance policy
- Developing a plan to identify needs for deferred maintenance for aging facilities and Americans with Disabilities Act (ADA) improvements, and maximize space utility

Over the past year, BHRS has made significant progress on the Strategic Initiatives listed above as well as implementing various initiatives under California's Advancing and Innovating Medi-Cal (CalAIM), planning to transition to a new Electronic Health Record (EHR), strengthening the children's crisis continuum of care, and implementing a local mobile crisis response.

In FY 2025-2026, BHRS will continue to prioritize several Strategic Initiatives that are outlined later in this

document. The Department plans to continue key collaborations with partners, stakeholders, consumers, and other community members to maintain the behavioral health of our region while building a system that achieves the most collective impact so that all residents can live well and thrive.

With gratitude and appreciation,

Ruben Imperial
Behavioral Health Director

Stanislaus County Demographic Profile at a Glance

Located in the heart of California's fertile San Joaquin Valley, Stanislaus County encompasses more than 1,500 square miles in size with a mix of rural areas and urban communities along the Highway 99 and Interstate 5 corridors. The city of Modesto is the county seat, the largest city in the county. Stanislaus County is home to 551,275 residents. It includes the cities of Modesto, Ceres, Turlock, Oakdale, Riverbank, Patterson, Hughson, Newman, and Waterford.

Of the Stanislaus County residents counted in the 2022 Census, 6.6% were, children under 5 years of age, 26.5% were children ages 0-18, 73.1% were adults ages 18-59, and 13.8% were adults ages 60 years and older. The majority, 50.3%, of persons in Stanislaus County are Latino/a. Persons who identified as White only represent 37.0% of the population, Asian represent 6.6% of the population, Black represent 3.7% of the population, American Indian/Alaskan Native represent 2.1% of the population, and those who identified as Multiracial represent 4.5% of the population. There is an almost equal proportion of females (50.1%), and males (49.9%) based on the Census; however, the data does not include persons who identify as non-binary.

It is estimated that about 42.8% of the population of Stanislaus County speaks a language other than English at home. Spanish remains the only threshold language in Stanislaus County. According to the 2022 US Census data, 15.0% of the county's residents live in poverty and 8.6% of persons are uninsured in Stanislaus County.

According to California Mental Health Prevalence Estimates (2012, Charles Holzer, HRSI, and TAC), approximately 5.74% of the population of Stanislaus County meet the criteria for serious mental illness and needs mental health services. The same study estimated that 14.48% of the population needs some type of mental health services but does not necessarily rise to the level to qualify for County Mental Health services.

Executive Summary

Stanislaus County Behavioral Health and Recovery Services (BHRS) is pleased to present the Mental Health Services Act Annual Update for FYs 2025-2026.

This Annual Update reflects MHSA programs and activities from July 1, 2023, to June 30, 2024. The Annual Update will serve the following purposes:

- Report actual results for programs and services that were funded by MHSA in FY 2023-2024 as required by MHSA Statue (W&I Code §5847). Information can be found on pages 33-186.
- Update the Three-Year Program and Expenditure Plan (PEP) for FY 2024-2025 as required by 9 CCR § 3310. The updated funding table and individual component worksheets can be found on pages 24-32.
- Outline programmatic changes that are being recommended, that if approved, will become effective in FY 2025-2026. Detail about the recommended changes can be found on pages 18-19.

This Annual Update is developed with feedback from the MHSA Advisory Committee. Information about the Community Program Planning Process can be found on pages 187-195 of this document.

Strategic Initiatives

BHRS Leadership continues to develop the behavioral health continuum of care, implement local impacts of California's Advancing and Innovating Medi-Cal (CalAIM) initiatives, and make strategic investments to build capacity in the Core Treatment Model (CTM) and administrative infrastructure and capabilities.

The Department has identified several new Strategic Initiatives that will be focus areas for opportunity over the coming year. A Strategic Initiative is comprised of multiple projects that align actions and resources to strengthen the capabilities to deliver CTM services as defined in the BHRS Strategic Plan, approved by the Board of Supervisors (BOS) on March 30, 2021 (Resolution No. 2021-0136). The Strategic Initiatives mainly emerged from areas of focus identified for further development in the approved Strategic Plan.

The MHSA Program and Expenditure Plan for FY 2025-2026 is recommended to align with existing Strategic Initiatives, and where additional funding has been identified, deepen the Department's commitment to the provision of quality behavioral health treatment and supports to the community by dedicated behavioral health workers and partnerships with community-based organizations. These investments will continue to increase the capacity of the Department's core treatment services to meet the needs of the Stanislaus County Medi-Cal beneficiaries and priority underserved and unserved populations.

BHRS will be focusing on several Strategic Initiatives for FY 2025-2026, which are outlined below.

California's Advancing and Innovating Medi-Cal

California's Advancing and Innovative Medi-Cal (CalAIM) is a long-term commitment to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory. The Department of Health Care Services (DHCS) and Counties are innovating and transforming the Medi-Cal delivery system and moving Medi-Cal towards a population health approach that prioritizes prevention and whole person care. The goal extends supports and services beyond hospitals and health care settings directly into California communities. The vision is to meet people where they are in life, address social drivers of health, and break down the walls of health care. CalAIM offers Medi-Cal enrollees coordinated and equitable access to services that address their physical, behavioral, developmental, dental, and long-term care needs, throughout their lives, from birth to a dignified end of life.

CalAIM goals:

- Address California's physical and behavioral health needs
- Improve and integrate care for California
- Be a catalyst for equity and justice
- Work together to build a healthier state

There are three main initiatives specific to behavioral health:

- Streamline and standardize how members access behavioral health services
- Improve Quality Outcomes
- Advance equity and reduce health disparities

BHRS is in the process of implementing the following deliverables in support of the CalAIM initiatives:

- New requirements under the Drug Medi-Cal Organized Delivery System 2022-2026
- Interoperability requirements
- Justice Involved initiatives
- Statewide Quality Measures

Over the past three years BHRS has been partnering and collaborating with other County Departments (Community Services Agency, Health Services Agency, Area Agency on Aging, Sheriff, and Probation), Managed Care Plans (Health Plan of San Joaquin and Health Net), and community Medi-Cal and other service providers on broader CalAIM initiatives that impact the behavioral health service delivery system:

- Enhanced Care Management (ECM) for populations of focus
- Community Supports designed to address social drivers of health
- Community Health Worker (CHW) to act as a bridge between formal health system and the community
- Ensuring continuity of coverage for justice-involved adults and youth

These broader initiatives will continue to be implemented in FY 2025-2026.

One Stop Shop for Supportive Services Facility Project

On January 24, 2023, the BOS approved the One Stop Shop for Supportive Services Facility Project, which required site improvements to the 800 Scenic Drive, Modesto campus to house a wraparound supportive

services model. This model creates a spectrum of behavioral health supportive services in one easily accessible site and aligns with BHRS' "whatever it takes approach" to assisting members and families with a serious mental illness (SMI), serious emotional disturbance (SED) or substance use disorder (SUD) who are experiencing homelessness or at risk of homelessness. The following programs were located at the site:

- Behavioral Health Advocacy
- Garden Gate Respite
- Behavioral Health Wellness Center
- Housing Services
- Employment Services

To accommodate the unique needs of the programs, site improvements included:

- Remodel of the existing restrooms to meet Americans with Disabilities Act (ADA) accessibility requirements
- Installation of ADA-compliant showering facilities
- Installation of a commercial kitchen for food preparation
- Installation of a member reception and interview area
- Other modifications in order to meet licensing or program requirements

Supportive Services

Senate Bill (SB) 803 (Chapter 150, Statutes of 2020) made it possible for certified peer support specialists to be eligible for Medi-Cal reimbursement through county behavioral health plans and substance use disorder plans (behavioral health plans). This important step in the delivery of behavioral health care values the experience that peers, persons with lived experience, can provide and expands counties' capacity to care for those who need them.

County behavioral health plans selected CalMHSA to implement a single, standardized Medi-Cal Peer Support Specialist certification program. This was done in recognition of the need for a uniform process across the state, one that does not require peers to obtain multiple certifications in multiple counties, supports quality and application of standards, creates efficiency for counties, and adds credibility to the peer profession in California. BHRS has implemented the Peer Support Specialist Certification in Stanislaus County and has been complying with labor requirements regarding impacts to staff.

Working with local development partners such as the Stanislaus Regional Housing Authority (SRHA) and the Stanislaus County Affordable Housing Corporation (STANCO), BHRS continues to make every effort to expand the inventory of available housing options for persons with an SMI, SED or SUD who are experiencing homelessness, or at risk of experiencing homelessness. As a result of these partnerships, over the past year additional permanent supportive housing units have become available for BHRS members.

Prevention and Early Intervention Efforts

In response to upcoming BHSA implementation, the PEI Community Collaborative model will be expanded to include stakeholder engagement that seeks to understand how to better improve treatment services, support members and their family through treatment, identify the partners in treatment and their respective roles and responsibilities, and how to measure members being better off after treatment.

Additionally, community collaboratives are being added that focus on priority populations such as veterans and support families with children receiving treatment outside of the county to better understand how to improve our services. Furthermore, community collaboratives are being established to focus on priority populations, including veterans, as well as providing support to families with children receiving treatment outside the county. These efforts aim to enhance our understanding of service improvements.

Innovation

The Embedded Neighborhood Mental Health Team (ENMHT) Innovations Project, also known as Stan Connect in the community, was approved by the Behavioral Health Services Oversight and Accountability Commission on April 27, 2023, and the Board of Supervisors on May 23, 2023. The ENMHT Innovations Project contract was awarded and approved by the Board of Supervisors on October 1, 2024, and at that time commenced. The Project will continue in FY 2025-26.

In the first 6-months of project implementation (October 2024 – March 2025) the Project Team was fully staffed; and all three neighborhood sites have been established in Riverbank, West Modesto and the Airport District. Through various outreach efforts, including community walkabouts, over 2,000 community members have been engaged with program collateral, information on what services are provided and the opportunity to refer someone to the Program. Case management and counseling services have been fully launched across the three sites with 41 unique members served.

Workforce Development and Training

Feedback received during development of the Strategic Plan in 2023-2024 indicated that additional focus was needed in this area, and a new division was created within BHRS to review existing training programs and suggest and implement enhancements and modifications to improve engagement, learning, and retention and to meet the changing needs of members, the organization and the behavioral health industry. The division is also developing partnerships with school districts, colleges and universities to introduce students to careers in behavioral health, introduce volunteer opportunities, and develop internship programs.

Additional MHSA WE&T funding has been utilized to increase training resources to expand clinical training, improve the utilization of evidence-based practices, implement a new paid internship program, and expand loan repayment and other retention programs. Workforce Development and Training (Training) has significantly expanded its partnerships, growing from two to twelve, thereby enhancing practicum and internship opportunities for both staff and the broader community. Since fall 2022, BHRS has hosted 67 interns, with 22% securing employment within the organization. Additionally, Training has strengthened its clinical and skill-building programs, increasing the number of offered trainings from 57 in 2022, 103 in 2023, 128 in 2024, and a projected 144 in 2025—reflecting a remarkable 152.6% growth. BHRS is dedicated to the continued development and use of these training programs in 2025-2026.

Building Administrative Capabilities and Infrastructure

BHRS has initiated work with GSA to develop a BHRS Master Facility Plan to address needs for deferred maintenance for aging facilities and Americans with Disabilities Act (ADA) improvements and maximize space utility. BHRS recommended MHSA Capital Facilities funding to support the project.

Funding for implementation of the new Electronic Health Record (EHR) was included in the FY 2022-2023 MHSA Annual Update, and the new system was implemented on July 1, 2023. BHRS is recommending MHSA Technological Needs funding to support ongoing operating costs for the EHR platform.
In FY 2022-2023, BHRS dedicated $500K Technological Needs funding to implement various Information Technology (IT) infrastructure projects to improve network uptime, protect the network, improve connectivity, ensure access, and refresh hardware. BHRS is recommending that MHSA Technological Needs funding be dedicated annually to support ongoing investments in these areas.

In FY2024-2025 and 2025-2026, to address the potential deficit in the CSS component and the CFTN component, the following operational changes are recommended:

- Redirect the Electronic Health Record contract in the amount of approximately $1 million out of CFTN into BHRS' primary Budget Unit for FY2024-2025 and 2025-2026.

Behavioral Health Equity Committee (BHEC)

BHRS is dedicated to implementing strategies that promote cultural diversity, inclusion, and the delivery of welcoming, compassionate behavioral health, and recovery services. These services are designed to be effective, equitable, and aligned with individuals' cultural health beliefs and practices. The BHEC strives to enhance service quality and address inequities and barriers to behavioral health care faced by marginalized cultural and ethnic communities.

Guided by established best practices, such as the Culturally and Linguistically Appropriate Services standards (CLAS), BHEC has developed recommendations to ensure the provision of high-quality care. These strategies focus on delivering effective, equitable, understandable, and respectful services that meet the diverse needs of individuals. This includes being responsive to cultural health beliefs and practices, accommodating preferred languages, addressing health literacy, and ensuring communication and language access.

Behavioral Health Equity Manager (BHEM)

The BHEM is responsible for ensuring that the County meets cultural and linguistic competency standards in the delivery of community-based behavioral health services, including Medi-Cal Specialty Mental Health Services (SMHS), Drug Medical-Cal Organized Delivery System (DMC-ODS) for substance use disorder (SUD) services, and Mental Health Service Act (MHSA)/ Behavioral Health Service Act (BHSA) services. The BHEM promotes and monitors quality and equitable care as it relates to diverse racial, ethnic, and cultural populations served by both county-operated and contracted behavioral health programs.

The BHEM developed strategies to ensure all programs continue to fully implement the CLAS standards. The BHEC agenda will include education on CLAS, review of best practices, and presentations from programs on their CLAS standards program development activities and progress. The initial strategies will focus on ensuring programs are adhering to and further developing the initial recommendation CLAS standards.

Additionally, the BHEC and BHEM will support the BHRS Department's efforts to launch Cultural Competency training: Building Bridges and Inclusivity and Community Interpreter Training. The training will introduce BHRS' commitment to cultural competency, including a discussion about CLAS Standards and the Cultural Competence Program for Stanislaus County – to include all policies and training requirements. BHRS has

updated and implemented the required eight-hour Cultural Competence training, and eight-hour Community Interpreter training facilitated by the Behavioral Health Equity Manager and a Workforce Development and Training staff (Coordinator/Manager). In addition, the Department will work with local diverse Prevention Community Collaboratives (PCC) to further expand their scope of practice to include supporting the Department in community stakeholder participation that will inform the further development and strengthening of treatment services for diverse community populations. The Behavioral Health Equity Manager will take the lead in providing information and will work with BHRS Departments to work with PCC to develop and provide educational sessions for treatment providers on the local diverse community experience in accessing and receiving behavioral health treatment services. To develop these educational sessions, the Department will partner PCC to convene learning sessions with BHRS members and community members to learn and gain insight into diverse community members and member challenges and successes in accessing behavioral health services. The educational sessions will vary in topic and include information on local, natural community support for members and families, and how treatment providers can connect clients to these community supports.

MHSA Changing Landscape

California's 2023-24 Proposed Budget projected that Personal Income Tax (PIT), the source for MHSA funds, would decline in FY 2022-2023, due to federal and state tax relief efforts due to storm damage, that allows individuals and business impacted by 2022-2023 winter storms to qualify for an extension to file and pay taxes until October 16, 2023. The State estimated that $500-600 million of MHSA revenue that would have been received in FY 2022-2023 would shift to 2023-2024. The Governor's 2024-25 Proposed Budget projected a decrease in MHSA revenue compared to FY 2023-2024.

Risk Factors and Mitigation Plans

Several risk factors could either cause a significant slowdown in revenue growth or lead to a recession. The impact of persistent supply chain issues, inflation, stock market volatility, and the lack of affordable housing are all issues that pose a risk to ongoing economic and revenue growth. Even in a moderate recession, revenue decline could be significant.

BHRS has been taking several actions to better prepare for such an eventuality: including re-establishing a strategic reserve and focusing on one-time spending over ongoing investments to maintain structurally balanced budgets over the long term. Due to the short-term risks outlined in the Governor's 2023-2024 Proposed Budget, BHRS assessed the local impacts and did not recommend significant adjustment to service levels in order to align program expenditures with available revenue.

Over the last several years, County behavioral health departments across the state have been criticized for MHSA funding kept in reserves when there is an ever-increasing need for treatment services. The Stanislaus County BHRS budget strategy followed a very aggressive plan to program available funds in FY 2023-2024 and aggressively monitor progress throughout the year for both actual spending levels and state budget projections to ensure that the maximum amount of funding was deployed to meet the needs of the community at that time. Based on the pace of spending and updates to state budget projections for FY 2025-2026, BHRS may either increase or decrease expenditure throughout the FY.

Behavioral Health Transformation Introducing Behavioral Health Services Act

In March 2024, California voters passed Proposition 1, a two-bill package to modernize the state's behavioral health care system, improve accountability and increase transparency, and expand the capacity of behavioral health care facilities. The efforts to implement Proposition 1, including the Behavioral Health Services Act (BHSA), are referred to as Behavioral Health Transformation (BHT). The BHT, is a policy manual that counties, providers, and other behavioral health stakeholders will find information on county planning, reporting, and fiscal requirements on BHSA.

The Behavioral Health Services Act Senate Bill 326:

- Reforms behavioral health care funding to provide services to individuals with serious mental illness and treat substance use disorders.
- Expands the behavioral health workforce to reflect and connect with California's diverse population.
- Focuses on outcomes, accountability, and equity.

The Behavioral Health Infrastructure Bond Act of 2024 (BHIBA) AB 531:

- Funds behavioral health treatment beds, supportive housing, and community sites through the Department of Health Care Services (DHCS).
- Directs funding for housing for veterans with behavioral health needs through the Department of Housing and Community Development (HCD).

BHSA further replaces the Mental Health Services Act (MHSA) 2004, effective January 1, 2025.

The reforms within the BHSA expand and increase the types of behavioral health supports available to Californians in need by focusing on historical gaps and emerging policy priorities.

The key opportunities for transformational change within the BHSA include:

- Reaching and Serving High Need Priority Populations
- Increasing Access to Substance Use Disorder Treatments
- Increasing Access to Housing Interventions with a focus on serving the chronically homeless residing in encampments
- Increasing Access to Evidence-Based Practices and Community-Defined Practices
- Building the Behavioral Health Workforce
- Focusing on Outcomes, Transparency, Accountability and Equity

The BHSA is the first major structural reform of the MHSA since it was passed in 2004. A crucial transformation under the BHSA pertains to the funding structure. The BHSA eliminates the five existing MHSA funding components, including the prevention component and introduces a new housing component. Under the BHSA, counties are mandated to allocate funds as follows:

- 35 percent of funds for Full-Service Partnership
- 35 percent of funds for Behavioral Health Services and Supports
- 30 percent of funds for Housing Interventions

Effective January 1, 2025, counties must engage the local stakeholders to develop each element of the Integrated Plan. With the revised community planning process, counties are required to demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on behavioral health policy, program planning and implementation, monitoring, workforce, quality improvement, evaluation, health equity, evaluation, and budget allocations. Meaningful stakeholder engagement requires that counties conduct a community planning process that is open to all interested stakeholders and that stakeholders have opportunities to provide feedback on key planning decisions.

Stanislaus County BHRS has been working with the collective California counties through the California Behavioral Health Directors Association (CBHDA) and Department of Healthcare Services (DHCS) to understand the scope of BHSA legislation and help define, clarify and shape BHSA policy and implementation guidance.

Stanislaus County actively participates in DHCS BHSA Workgroups, CBHDA BHSA Workgroups, and internal BHRS BHSA workgroups to ensure we are actively engaging, advocating and aligning our programs and services with the needs of the community we serve and the goals of BHSA.

New BHSA Reporting Requirements

The BHSA requires counties to submit a 3-year Integrated Plan and annual Behavioral Health Outcomes, Accountability, and Transparency Report (Plans) for behavioral health services and outcomes in alignment with statewide behavioral health goals established by the DHCS. Whereas the 3-Year Program and Expenditure Plan and Annual Update required under the MHSA focused exclusively on MHSA funding, the BHSA establishes the Plans to serve as a global spending plan that describes how county behavioral health departments plan to use all available behavioral health funding, including BHSA, 1991 and 2011 Realignment, federal block grant programs, Substance Use Prevention, Treatment and Recovery Services Block Grant (SUBG), federal financial participation from Medi-Cal, opioid settlement funds, any other federal, state, or local funding directed towards county behavioral health department services, and other funding to meet statewide and local outcome measures, reduce disparities, and address the unmet need in their community. The County Board of Supervisors must certify within each plan that the county is meeting their realignment obligations.

In accordance with the BHSA, the Plans provides a description of how counties will plan expenditures across a range of behavioral health funding sources and deliver high-quality, culturally responsive, and timely care along the Behavioral Health Care Continuum for the plan period.

- Draft Integrated Plan will cover FYs 2026-2029 and will be due on June 30, 2026.
- Final first Board of Supervisors approved Integrated Plan will be due on June 30, 2026.
- Board of Supervisors approved County Annual Update for FY 2027-28 due June 30, 2027
- Draft Behavioral Health Outcomes, Accountability, and Transparency Report for FY 2026-2027 due January 30, 2028
- Final Behavioral Health Outcomes, Accountability, and Transparency Report for FY 2026-2027 due January 30, 2029

18-Month Phased BHSA Timeline

Stanislaus County BHRS has framed the following 18-month internal timeline to plan for and implement the BHSA.

1st Phase: January 2025-June 2025	2nd Phase: July 2025- December 2025	3rd Phase: January 2026- June 30, 2026
Workgroup and BHSA team to meet and begin discussing impacts of BHSA and required changes to implement BHSA by deadline. What are our top priorities? Departmental initiatives? Community Needs? System Gaps? Conducting an internal analysis and developing a Strategy Plan for the transition process.	Deliver the Strategy Plan to leadership for review and approval. Initiate actions to formulate recommendations within the Strategy Plan, which may include drafting policies, establishing contracts, and enhancing existing services to incorporate BHSA services.	Begin implementing BHSA changes within the Strategy Plan.

Stanislaus County BHRS is committed to engaging community partners and stakeholders in the development and planning for BHSA and the transition from MHSA. BHSA has been a focus of the Mental Health Advisory Committee (MAC) meetings, and the Department will continue to pursue opportunities to expand community outreach and engagement and solicit feedback into BHSA initiatives as they are being developed.

FY 2025-2026 Program and Expenditure Plan

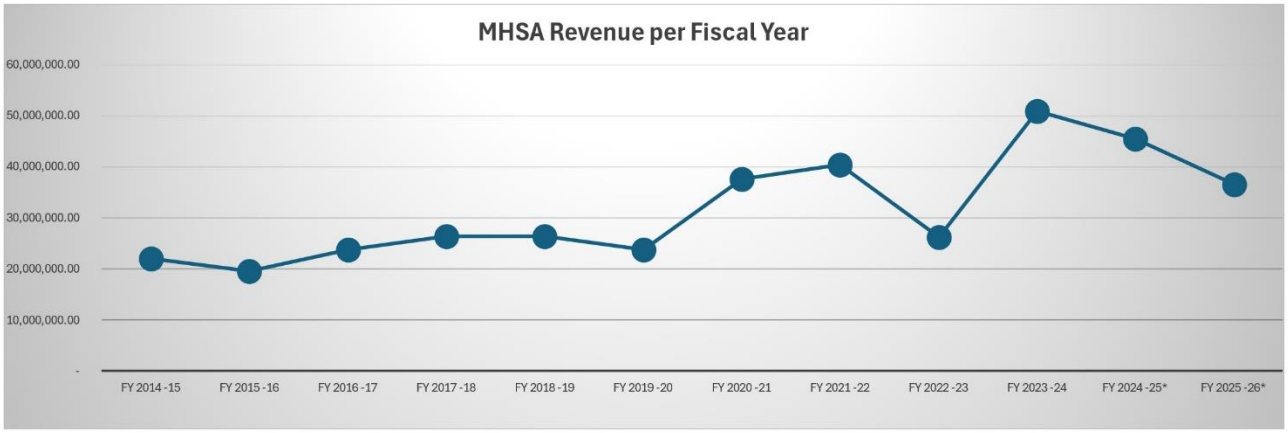
This section of the document provides an overview of programmatic and service level changes that are being recommended for implementation as part of the Program and Expenditure Plan (PEP) for FY 2025-2026. Information about allowable services and activities in each of the components can be found on pages 19-23 of this report.

Consistent with direction from the County's Chief Executive Office (CEO), BHRS used the following assumptions to develop the PEP:

- Used FY 2024-2025 Midyear Budget as base
- Added a 3% escalator for salaries and benefits to account for cost-of-living increases
- Added a 2.7% escalator for services and supplies, where costs are not already known, to account for cost-of-living increases
- Used the County Cost Allocation Plan (CAP) figures from data provided by CEO

Estimated MHSA Funding Allocation for FY 2025-2026

Per the Governor's 2025-2026 Proposed Budget, a small increase in MHSA revenue is projected compared to FY 2024-2025. Stanislaus County will be allocated approximately 1.320470% of the statewide MHSA collections. Given the volatile nature of the MHSA funds, BHRS has carefully developed a conservative strategy in estimating MHSA revenues. In FY 2025-2026, BHRS is projecting approximately $36.9 million in new funding and interest earned on existing MHSA fund balance. Since the all-time high of $50M in FY 23-24, we have seen a decrease in funding of 10.6% in FY 24-25, and a projected 19.5% decrease in FY 25-26. This has created a deficit in the Community Services and Supports component that is being addressed by the following recommendations.



- Community Services and Supports (CSS) $27.9 million
- Prevention and Early Intervention (PEI) $7. million
- Innovation (INN) $2.0 Million

Community Services and Supports

In 2025-2026, to address the potential deficit in the CSS component, the following operational changes are recommended:

- Redirect the Adult Residential Facilities contracts in the amount of approximately $12 million out of CSS into BHRS' primary Budget Unit.
- Reduce the transfer amount from the CSS component into the CFTN component in FY2024-2025 and 2025-2026.

Prevention and Early Intervention

Program changes and fiscal impacts resulting from the implementation of the Behavioral Health Services Act (BHSA) are being considered. No service level changes are being recommended by BHRS.

Innovation

Program changes and fiscal impacts resulting from the implementation of the Behavioral Health Services Act (BHSA) are being considered. No service level changes are being recommended by BHRS.

Workforce Education and Training

Program changes and fiscal impacts resulting from the implementation of the Behavioral Health Services Act (BHSA) are being considered. No service level changes are being recommended by BHRS.

Capital Facilities and Technological Needs (CFTN)

In FY2024-2025 and 2025-2026, to address the potential deficit in the CSS component and the Capital Facilities and Technology (CFTN) component, the following operational changes are recommended:

- Redirect the Electronic Health Record contract in the amount of approximately $1 million out of CFTN into BHRS' primary Budget Unit for FY2024-2025 and 2025-2026.

Housing

Program changes and fiscal impacts resulting from the implementation of the Behavioral Health Services Act (BHSA) are being considered. No service level changes are being recommended by BHRS.

MHSA Components Defined

Community Services and Supports

Community Services and Supports (CSS) is defined as mental health services and supports for children and youth, transition age youth, adults, and older adults. These services and supports are similar to those found in Welfare and Institutions Code sections 5800 et. seq. (Adult and Older Adult Systems of Care) and 5850 et. seq. (Children's System of Care) (9 CCR § 3200.080) and has three categories:

- **Full Services Partnership (FSP)** is a service where 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 (9 CCR § 3200.140).
- **General System Development (GSD)** services are designed to improve the County's mental health service delivery system for all members and/or to pay for specified mental health services and supports for members, and/or when appropriate their families (9 CCR § 3200.170).
- **Outreach and Engagement (O&E)** are activities to reach, identify, and engage unserved individuals and communities in the mental health system and reduce disparities identified by the County (9 CCR § 3200.240).

Prevention and Early Intervention

Prevention and Early Intervention (PEI) services are intended to prevent mental illnesses from becoming severe and disabling (9 CCR § 3200.245) and the component has five (5) categories:

- **Prevention** is defined as a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. The goal of these programs is to bring about mental health including reduction of the applicable negative outcomes listed in Welfare and Institutions Code Section 5840(d) as a result of untreated mental illness for individuals and members of groups or populations whose risk of developing a serious mental illness is greater than average and, as applicable, their parents, caregivers, and other family members (9 CCR § 3720).
- **Early Intervention** is defined as 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 listed in Welfare and Institutions Code Section 5840(d) that may result from untreated mental illness)9 CCR § 3710).
- **Stigma and Discrimination Reduction** services are 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 (9 CCR § 3725).
- **Access and Linkage to Treatment** is a set of related activities to connect children with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, and adults and seniors with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, 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 (9 CCR § 3726).

- **Suicide Prevention** is organized activities that the County undertakes to prevent suicide as a consequence of mental illness. This category of programs does not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness (9 CCR § 3730).

At least 51% of PEI funding must be dedicated to serving individuals 25 years or younger (9 CCR § 3706 (b)).

Innovation

Innovation (INN) is a project that the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports (9 CCR § 3200.184) to:

- Introduce a mental health practice or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention.
- Make a change to an existing practice in the field of mental health, including but not limited to, application to a different population.
- Apply to the mental health system a promising community-driven practice or approach that has been successful in non-mental health contexts or settings.

Workforce Education and Training

Workforce Education and Training (WE&T) contains five (5) categories:

- **Training and Technical Assistance** programs and/or activities increase the ability of the Public Mental Health System workforce to do the following (9 CCR § 3841):
    - Promote and support the General Standards in 9 CCR § 3320.
    - Support the participation of members and family members of members in the Public Mental Health System.
    - Increase collaboration and partnerships among Public Mental Health System staff and individuals and/or entities that participate in and support the provision of services in the Public Mental Health System.
    - Promote cultural and linguistic competence.
- **Mental Health Career Pathways** funds may support (9 CCR § 3842):
    - Programs to prepare members and/or family members of members for employment and/or volunteer work in the Public Mental Health System.
    - Programs and coursework in high schools, adult education, regional occupational programs, colleges and universities that introduce individuals to and prepare them for employment in the Public Mental Health System.
    - Career counseling, training and/or placement programs designed to increase access to employment in the Public Mental Health System to groups such as immigrant communities, Native Americans and racial/ethnic, cultural and linguistic groups that are underrepresented in the Public Mental Health System, as underrepresentation is defined in Government Code § 11139.6.
    - Focused outreach and engagement in order to provide equal opportunities for employment to individuals who share the racial/ethnic, cultural and linguistic characteristics of the members served.

- Supervision of employees in Public Mental Health System occupations that are in a Mental Health Career Pathway Program.

- **Residency and Internship Programs** funds may support (9 CCR § 3843):
  - Time required of staff, including university faculty, to supervise psychiatric residents training to work in the Public Mental Health System.
  - Time required of staff, including university faculty, to supervise post-graduate interns training to work as psychiatric nurse practitioners, Master of Social Work, marriage and family therapists, or clinical psychologists in the Public Mental Health System.
    - Only faculty time spent supervising interns in programs designed to lead to licensure is eligible.
  - Time required of staff, including university faculty, to train psychiatric technicians to work in the Public Mental Health System.
  - Time required of staff, including university faculty, to train physician assistants to work in the Public Mental Health System and to prescribe psychotropic medications under the supervision of a physician.
  - Addition of a mental health specialty to a physician assistant program.
- **Financial Incentive Programs** may be used to that address one or more of the occupational shortages identified in the County's Workforce Needs Assessment. Financial Incentive Programs include (9 CCR § 3844):
  - Scholarships
  - Stipends
  - Loan Repayment Programs
- **Workforce Staffing Support** is defined as staff needed to plan, administer, coordinate and/or evaluate Workforce Education and Training programs and activities (9 CCR § 3200.325).

Capital Facilities and Technological Needs

Capital Facilities and Technological Needs (CFTN) is defined as projects for the acquisition and development of land and the construction or renovation of buildings or the development, maintenance or improvement of information technology for the provision of Mental Health Services Act administration, services, and supports. Capital Facilities and Technological Needs does not include housing projects (9 CCR § 3200.022).

Prudent Reserve

Per W&IC 5847(b)(7), counties are required to establish and maintain a Prudent Reserve to ensure children, adults, and seniors can continue receiving services at current levels in the event of an economic downturn. The Prudent Reserve is funded with revenue allocated to the Community Services and Supports component and cannot exceed 33% of a county's average distribution for the previous five years.

MHSA Populations Defined

MHSA funds are designed to provide services to several priority populations that are outlined below.

Underserved

Underserved is defined as a client of any age who has 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 his/her recovery, wellness and/or resilience (9 CCR § 3200.300). When appropriate, it includes members whose family members are not receiving sufficient services to support the client's recovery, wellness and/or resilience. These members 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
- Those in rural areas, Native American rancherias and/or reservations who are not receiving sufficient services.

Unserved

Unserved is defined as those individuals who may have serious mental illness and/or serious emotional disturbance and are not receiving mental health services (9 CCR § 3200.310). Individuals who may have had only emergency or crisis-oriented contact with and/or services from the County may be considered unserved.

Transition Aged Youth
Transition Age Youth is defined as youth 16 years to 25 years of age (9 CCR § 3200.280).

Funding Allocation

The distribution of MHSA funds takes place on a monthly basis (W&I Code Section 5892(j)(5)) and counties are responsible for ensuring that funds are spent in compliance with W&I Code Section 5892(a):

- 76% for Community Services and Supports (CSS)
- 19% for Prevention and Early Intervention (PEI)
- 5% for Innovations programs (INN)

Annually, based on an average of the past five years allocation, up to 20% of CSS funds may be used for any one or a combination of Workforce, Education and Training, Capital Facilities, Technological Needs, or Prudent Reserve.

Counties receive monthly payments from the California State Controller’s Office (SCO) based on an available cash basis. MHSA can be a volatile funding source and is driven by the state of the economy and the way in which state income taxes are assessed and paid. Due to potential volatility in funding, sufficient cash flow to support and sustain MHSA programs is needed. In the event of an economic downturn, programmatic changes will need to be recommended. BHRS estimates the availability of MHSA funding based on the projections provided in the California State Budgets and analysis provided by the County Behavioral Health Directors Association (CBHDA).

FYs 2025-2026 Funding Summary Table and Component Worksheets

The MHSA Program and Expenditure Plan for FY 2023-2026 is shown in the following tables that are summarized at the funding component level. The MHSA funding recommendations were included in the BHRS' FY 2025-2026 Proposed Budget request, which will be considered by the Board of Supervisors on June 10, 2025. If approved, the PEP will be effective July 1, 2025, through June 30, 2026. Expenditure and revenue projections are updated during each budget cycle and material changes will be discussed during the Community Program Planning Process outlined on page 187 of this document.

Funding Summary Table

FY 2023-24 Through 2025-26 Mental Health Services Act Expenditure Plan
Funding Summary

County: Stanislaus — Date: 3/4/2025

	MHSA Funding							
	A	B	C	D	E		F	G
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Housing (Returned from CalHFA)	Prudent Reserve	Total
A. FY2023/24 Funding								
1. Unspent Funds from Prior Fiscal Years	1,871,897	5,810,327	5,404,262	934,044	1,450,472	27,863	500,000	15,998,865
2. New FY2023/24 Funding + Interest	38,592,190	9,650,868	2,567,804	7,245	39,810	-	-	50,857,917
3. Transfer in FY2023/24[a/]	(4,000,000)			500,000	3,500,000		-	-
4. Access Local Prudent Reserve in FY2023/24	-	-					-	-
5. Available Funding for FY2023/24	36,464,087	15,461,195	7,972,066	1,441,289	4,990,283	27,863		66,356,782
B. FY2023/24 Expenditures	33,108,819	7,031,617	898,827	911,956	4,416,922	-	-	46,368,140
C. Estimated FY2024/25 Funding								
1. Estimated Unspent Funds from Prior Fiscal Years	3,355,268	8,429,579	7,073,239	529,333	573,361	27,863	500,000	20,488,643
2. Estimated New FY2024/25 Funding + Interest	36,648,076	8,118,968	2,261,236	1,400	1,000	-		47,030,680
3. Transfer in FY2024/25[a/]	(200,000)			200,000	-		-	-
4. Access Local Prudent Reserve in FY2024/25	-	-					-	-
5. Estimated Available Funding for FY2024/25	39,803,344	16,548,547	9,334,475	730,733	574,361	27,863		67,019,323
D. Estimated FY2024/25 Expenditures	37,904,952	8,274,949	2,093,566	1,035,820	1,117,825	9,263	-	50,436,375
E. Estimated FY2025/26 Funding								
1. Estimated Unspent Funds from Prior Fiscal Years	1,898,392	8,273,597	7,240,909	(305,087)	(543,464)	18,600	500,000	17,082,947
2. Estimated New FY2025/26 Funding + Interest	27,326,725	7,063,029	1,919,218	640,391	-	-		36,949,363
3. Transfer in FY2025/26[a/]	(848,551)			305,087	543,464		-	-
4. Access Local Prudent Reserve in FY2025/26	-	-					-	-
5. Estimated Available Funding for FY2025/26	28,376,566	15,336,626	9,160,127	640,391	-	18,600		53,532,310
F. Estimated FY2025/26 Expenditures	33,184,402	8,938,173	1,820,389	635,792	-	10,000	-	44,588,756

Community Services and Supports Component Worksheets

		Fiscal Year 2023/24					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs							
1.	Adult Behavioral Health Services Team	12,964,835	3,549,240	9,390,676	-	-	24,919
2.	Adult Medication Clinic	3,683,140	932,630	2,724,119	-	-	26,391
3.	Children and Transition Age Youth Behavioral Health Services Team	6,310,286	1,489,054	4,819,927	-	-	1,305
Non-FSP Programs							
	O&E Programs						
4.	Behavioral Health Outreach and Engagement	1,051,901	1,031,397	20,504	-	-	-
5.	Assisted Outpatient Treatment	165,103	164,559	544	-	-	-
6.	Housing Support Services	1,590,408	1,590,408	-	-	-	-
7.	Garden Gate Respite	1,126,559	1,126,559	-	-	-	-
8.	Short-Term Shelter and Housing	42,219	42,219	-	-	-	-
9.	Homelessness Access Center Integration	117,639	117,639	-	-	-	-
10.	Community Assessment, Response, and Engagement	1,565,650	439,184	121,130	-	-	1,005,336
	GSD Programs						
11.	Adult Residential Facilities	11,535,915	11,192,382	-	-	-	343,533
12.	Residential Substance Use Disorder Board and Care	82,046	82,046	-	-	-	-
13.	Housing Placement Assistance	751,325	751,325	-	-	-	-
14.	Employment Support Services	487,294	432,039	-	-	-	55,255
15.	Behavioral Health Wellness Center	1,310,074	1,310,074	-	-	-	-
16.	Behavioral Health Crisis and Support Line	2,748,111	2,594,968	3,676	-	-	149,467
17.	Short Term Residential Therapeutic Programs	2,165,468	632,038	1,533,430	-	-	-
18.	Crisis Residential Unit	1,049,837	837,134	212,703	-	-	-
19.	Therapeutic Foster Care Services	-	-	-	-	-	-
20.	GSD Portion of Adult Medication Clinic	378,057	98,439	279,618	-	-	-
CSS Administration		6,340,059	4,695,486	1,644,553	-	-	20
CSS MHSA Housing Program Assigned Funds		-	-	-	-	-	-
Total CSS Program Expenditures		55,465,926	33,108,820	20,750,880	-	-	1,606,226
FSP Programs as Percent of Total		69.3%					

		Fiscal Year 2024/25					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs							
1.	Adult Behavioral Health Services Team	14,573,489	2,904,835	11,668,654	-	-	-
2.	Adult Medication Clinic	3,468,603	206,562	3,262,041	-	-	-
3.	Children and Transition Age Youth Behavioral Health Services Team	6,489,894	1,627,211	4,862,683	-	-	-
Non-FSP Programs							
	O&E Programs						
4.	Behavioral Health Outreach and Engagement	1,152,650	1,135,795	16,855	-	-	-
5.	Assisted Outpatient Treatment	218,622	212,578	6,044	-	-	-
6.	Housing Support Services	1,752,506	1,752,506	-	-	-	-
7.	Garden Gate Respite	538,734	538,734	-	-	-	-
8.	Short-Term Shelter and Housing	9,773	9,773	-	-	-	-
9.	Homelessness Access Center Integration	77,550	77,550	-	-	-	-
10.	Community Assessment, Response, and Engagement	1,749,937	1,303,437	279,471	-	-	167,029
	GSD Programs						
11.	Adult Residential Facilities	12,716,841	12,716,841	-	-	-	-
12.	Residential Substance Use Disorder Board and Care	106,774	106,774	-	-	-	-
13.	Housing Placement Assistance	916,177	916,177	-	-	-	-
14.	Employment Support Services	641,622	556,199	-	-	-	85,423
15.	Behavioral Health Wellness Center	1,646,437	1,646,437	-	-	-	-
16.	Behavioral Health Crisis and Support Line	3,024,284	2,904,244	37,858	-	-	82,182
17.	Short Term Residential Therapeutic Programs	4,620,820	2,209,442	2,411,378	-	-	-
18.	Crisis Residential Unit	1,352,736	676,368	676,368	-	-	-
19.	Therapeutic Foster Care Services	-	-	-	-	-	-
20.	GSD Portion of Adult Medication Clinic	840,221	50,037	790,184	-	-	-
CSS Administration		7,998,006	6,353,453	1,644,553	-	-	-
CSS MHSA Housing Program Assigned Funds		-	-	-	-	-	-
Total CSS Program Estimated Expenditures		63,895,676	37,904,953	25,656,089	-	-	334,634
FSP Programs as Percent of Total		64.7%					

		Fiscal Year 2025/26					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs							
1.	Adult Behavioral Health Services Team	20,148,313	6,743,213	13,405,100	-	-	-
2.	Adult Medication Clinic	4,453,387	1,371,847	3,081,540	-	-	-
3.	Children and Transition Age Youth Behavioral Health Services Team	7,122,312	2,302,312	4,820,000	-	-	-
Non-FSP Programs							
	O&E Programs						
4.	Behavioral Health Outreach and Engagement	1,606,382	1,591,382	15,000	-	-	-
5.	Assisted Outpatient Treatment	425,472	420,472	5,000	-	-	-
6.	Housing Support Services	2,459,861	2,459,861	-	-	-	-
7.	Garden Gate Respite	1,071,559	1,071,559	-	-	-	-
8.	Short-Term Shelter and Housing	67,666	67,666	-	-	-	-
9.	Homelessness Access Center Integration	127,600	127,600	-	-	-	-
10.	Community Assessment, Response, and Engagement	1,980,406	781,426	179,000	-	-	1,019,980
	GSD Programs						
11.	Adult Residential Facilities	-	-	-	-	-	-
12.	Residential Substance Use Disorder Board and Care	117,253	117,253	-	-	-	-
13.	Housing Placement Assistance	886,953	886,953	-	-	-	-
14.	Employment Support Services	402,791	317,368	-	-	-	85,423
15.	Behavioral Health Wellness Center	1,521,338	1,521,338	-	-	-	-
16.	Behavioral Health Crisis and Support Line	2,800,013	2,775,013	25,000	-	-	-
17.	Short Term Residential Therapeutic Programs	5,584,796	2,098,796	3,486,000	-	-	-
18.	Crisis Residential Unit	756,543	532,543	224,000	-	-	-
19.	Therapeutic Foster Care Services	769,440	384,720	384,720	-	-	-
20.	GSD Portion of Adult Medication Clinic	1,078,771	332,311	746,460	-	-	-
CSS Administration		7,780,769	7,280,769	500,000	-	-	-
CSS MHSA Housing Program Assigned Funds		-	-	-	-	-	-
Total CSS Program Estimated Expenditures		61,161,625	33,184,402	26,871,820	-	-	1,105,403
FSP Programs as Percent of Total		95.6%					

Prevention and Early Intervention Component Worksheets

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Promotores/Community Health Outreach Workers	1,572,692	1,143,615	-	-	-	429,077
2. Child and Youth Resiliency Prevention	145,619	145,619	-	-	-	-
PEI Programs - Early Intervention						
3. Early Psychosis Intervention	300,839	205,794	95,024	-	-	21
4. School Behavioral Health Integration	2,555,300	920,266	1,634,771	-	-	263
5. Children's Early Intervention	1,762,347	1,132,432	628,306	-	-	1,610
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
6. Outreach for Increasing Recognition of Early Signs of Mental Illness	287,294	287,294	-	-	-	-
7. Community Based Cultural and Ethnic Engagement	55,886	55,886	-	-	-	-
8. Training and Education	51,408	51,408	-	-	-	-
PEI Programs -Stigma & Discrimination Reduction						
9. Stigma & Discrimination Reduction	273,324	273,324	-	-	-	-
PEI Programs -Suicide Prevention						
10. Suicide Prevention	61,418	61,418	-	-	-	-
PEI Programs -Access and Linkage						
11. Older Adult and Veteran Access and Linkage	393,120	393,120	-	-	-	-
PEI Administration and Evaluation	2,293,729	2,293,729	-	-	-	-
PEI Assigned Funds	67,710	67,710	-	-	-	-
Total PEI Program Expenditures	9,820,687	7,031,617	2,358,100	-	-	430,970

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Promotores/Community Health Outreach Workers	944,437	944,437	-	-	-	-
2. Child and Youth Resiliency Prevention	382,545	382,545	-	-	-	-
PEI Programs - Early Intervention						
3. Early Psychosis Intervention	590,551	478,599	111,952	-	-	-
4. School Behavioral Health Integration	2,811,144	1,639,716	1,171,428	-	-	-
5. Children's Early Intervention	1,952,273	1,219,423	732,850	-	-	-
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
6. Outreach for Increasing Recognition of Early Signs of Mental Illness	257,298	257,298	-	-	-	-
7. Community Based Cultural and Ethnic Engagement	121,466	121,466	-	-	-	-
8. Training and Education	52,951	52,951	-	-	-	-
PEI Programs -Stigma & Discrimination Reduction						
9. Stigma & Discrimination Reduction	327,571	327,571	-	-	-	-
PEI Programs -Suicide Prevention						
10. Suicide Prevention	143,046	143,046	-	-	-	-
PEI Programs -Access and Linkage						
11. Older Adult and Veteran Access and Linkage	423,120	423,120	-	-	-	-
PEI Administration and Evaluation	2,235,571	2,235,571	-	-	-	-
PEI Assigned Funds	49,206	49,206	-	-	-	-
Total PEI Program Estimated Expenditures	10,291,179	8,274,949	2,016,230	-	-	-

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Promotores/Community Health Outreach Workers	997,585	997,585	-	-	-	-
2. Child and Youth Resiliency Prevention	390,000	390,000	-	-	-	-
PEI Programs - Early Intervention						
3. Early Psychosis Intervention	590,551	490,551	100,000	-	-	-
4. School Behavioral Health Integration	3,811,046	1,394,046	2,417,000	-	-	-
5. Children's Early Intervention	2,580,295	1,674,295	906,000	-	-	-
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
6. Outreach for Increasing Recognition of Early Signs of Mental Illness	253,682	253,682	-	-	-	-
7. Community Based Cultural and Ethnic Engagement	770,000	770,000	-	-	-	-
8. Training and Education	60,833	60,833	-	-	-	-
PEI Programs -Stigma & Discrimination Reduction						
9. Stigma & Discrimination Reduction	352,490	352,490	-	-	-	-
PEI Programs -Suicide Prevention						
10. Suicide Prevention	273,486	273,486	-	-	-	-
PEI Programs -Access and Linkage						
11. Older Adult and Veteran Access and Linkage	393,120	393,120	-	-	-	-
PEI Administration and Evaluation	1,775,375	1,775,375	-	-	-	-
PEI Assigned Funds	112,710	112,710	-	-	-	-
Total PEI Program Estimated Expenditures	12,361,173	8,938,173	3,423,000	-	-	-

Innovations Component Worksheets

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. NAMI on Campus High School Innovation Plan	208,553	208,553	-	-	-	-
2. Full-Service Partnership (FSP) Multi-County Collaborative	210,344	210,344	-	-	-	-
3. Early Psychosis Learning Health Care Network (LHCN) Multi-County Collaborative	183,398	183,398	-	-	-	-
4. Community Program Planning	78,031	78,031	-	-	-	-
5. Embedded Neighborhood Mental Health Team	-	-	-	-	-	-
6. New Requests for Proposals	14,240	14,240	-	-	-	-
INN Administration	204,261	204,261	-	-	-	-
Total INN Program Expenditures	898,827	898,827	-	-	-	-

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. NAMI on Campus High School Innovation Plan	200,000	200,000	-	-	-	-
2. Full-Service Partnership (FSP) Multi-County Collaborative	218,373	218,373	-	-	-	-
3. Early Psychosis Learning Health Care Network (LHCN) Multi-County Collaborative	195,154	195,154	-	-	-	-
4. Community Program Planning	52,624	52,624	-	-	-	-
5. Embedded Neighborhood Mental Health Team	1,000,000	1,000,000	-	-	-	-
6. New Requests for Proposals	-	-	-	-	-	-
INN Administration	427,416	427,416	-	-	-	-
Total INN Program Estimated Expenditures	2,093,566	2,093,566	-	-	-	-

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. NAMI on Campus High School Innovation Plan	200,000	200,000	-	-	-	-
2. Full-Service Partnership (FSP) Multi-County Collaborative	73,921	73,921	-	-	-	-
3. Early Psychosis Learning Health Care Network (LHCN) Multi-County Collaborative	122,281	122,281	-	-	-	-
4. Community Program Planning	124,000	124,000	-	-	-	-
5. Embedded Neighborhood Mental Health Team	1,000,000	1,000,000	-	-	-	-
6. New Requests for Proposals	0		-	-	-	-
INN Administration	300,186	300,186	-	-	-	-
Total INN Program Estimated Expenditures	1,820,389	1,820,389	-	-	-	-

Workforce Education and Training Component Worksheets

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce Staffing	-	-	-	-	-	-
2. Training/Technical Assistance	397,167	397,167	-	-	-	-
3. Mental Health Career Pathways	391,439	391,439	-	-	-	-
4. WET Central Region Partnership	15,630	15,630	-	-	-	-
5. Financial Incentive	-	-	-	-	-	-
WET Administration	107,720	107,720	-	-	-	-
Total WET Program Expenditures	911,956	911,956	-	-	-	-

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce Staffing	-	-	-	-	-	-
2. Training/Technical Assistance	150,000	150,000	-	-	-	-
3. Mental Health Career Pathways	150,000	150,000	-	-	-	-
4. WET Central Region Partnership	181,478	181,478	-	-	-	-
5. Financial Incentive	5,000	5,000	-	-	-	-
WET Administration	549,342	549,342	-	-	-	-
Total WET Program Estimated Expenditures	1,035,820	1,035,820	-	-	-	-

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce Staffing	-	-	-	-	-	-
2. Training/Technical Assistance	150,000	150,000	-	-	-	-
3. Mental Health Career Pathways	150,000	150,000	-	-	-	-
4. WET Central Region Partnership	216,442	216,442	-	-	-	-
5. Financial Incentive	5,000	5,000	-	-	-	-
WET Administration	114,350	114,350	-	-	-	-
Total WET Program Estimated Expenditures	635,792	635,792	-	-	-	-

Capital Facilities and Technological Needs Component Worksheets

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. One Stop Shop for Supportive Services	1,512,704	1,512,704	-	-	-	-
2. BHRS Master Facility Plan	267,737	267,737	-	-	-	-
CFTN Programs - Technological Needs Projects						
6. Electronic Health Record (EHR System)	254,419	254,419	-	-	-	-
7. Consumer Family Access	30,137	30,137	-	-	-	-
8. Electronic Health Data Warehouse	-	-	-	-	-	-
9. Document Imaging	-	-	-	-	-	-
10. New Electronic Health Record System	1,253,379	1,253,379	-	-	-	-
11. New Infrastructure	1,098,546	1,098,546	-	-	-	-
CFTN Administration	-	-	-	-	-	-
Total CFTN Program Expenditures	4,416,922	4,416,922	-	-	-	-

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. One Stop Shop for Supportive Services	-	-	-	-	-	-
2. BHRS Master Facility Plan	155,400	155,400	-	-	-	-
CFTN Programs - Technological Needs Projects						
6. Electronic Health Record (EHR System)	62,839	62,839	-	-	-	-
7. Consumer Family Access	30,263	30,263	-	-	-	-
8. Electronic Health Data Warehouse	-	-	-	-	-	-
9. Document Imaging	-	-	-	-	-	-
10. New Electronic Health Record System	869,323	869,323	-	-	-	-
11. New Infrastructure	-	-	-	-	-	-
CFTN Administration	-	-	-	-	-	-
Total CFTN Program Estimated Expenditures	1,117,825	1,117,825	-	-	-	-

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	-	-	-	-	-	-
2.	-	-	-	-	-	-
CFTN Programs - Technological Needs Projects						
6. Electronic Health Record (EHR System)	-	-	-	-	-	-
7. Consumer Family Access	-	-	-	-	-	-
8. Electronic Health Data Warehouse	-	-	-	-	-	-
9. Document Imaging	-	-	-	-	-	-
10. New Electronic Health Record System	-	-	-	-	-	-
11. New Infrastructure	-	-	-	-	-	-
CFTN Administration	-	-	-	-	-	-
Total CFTN Program Estimated Expenditures	-	-	-	-	-	-

Housing Component Worksheets

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated Housing Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Housing Programs						
1. Housing Project	-	-				
Housing Administration	-					
Total Housing Program Expenditures	-	-	-	-	-	-

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated Housing Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Housing Programs						
1. Housing Project	9,263	9,263				
Housing Administration	-					
Total Housing Program Estimated Expenditures	9,263	9,263	-	-	-	-

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated Housing Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Housing Programs						
1. Housing Project	10,000	10,000				
Housing Administration	-					
Total Housing Program Estimated Expenditures	10,000	10,000	-	-	-	-

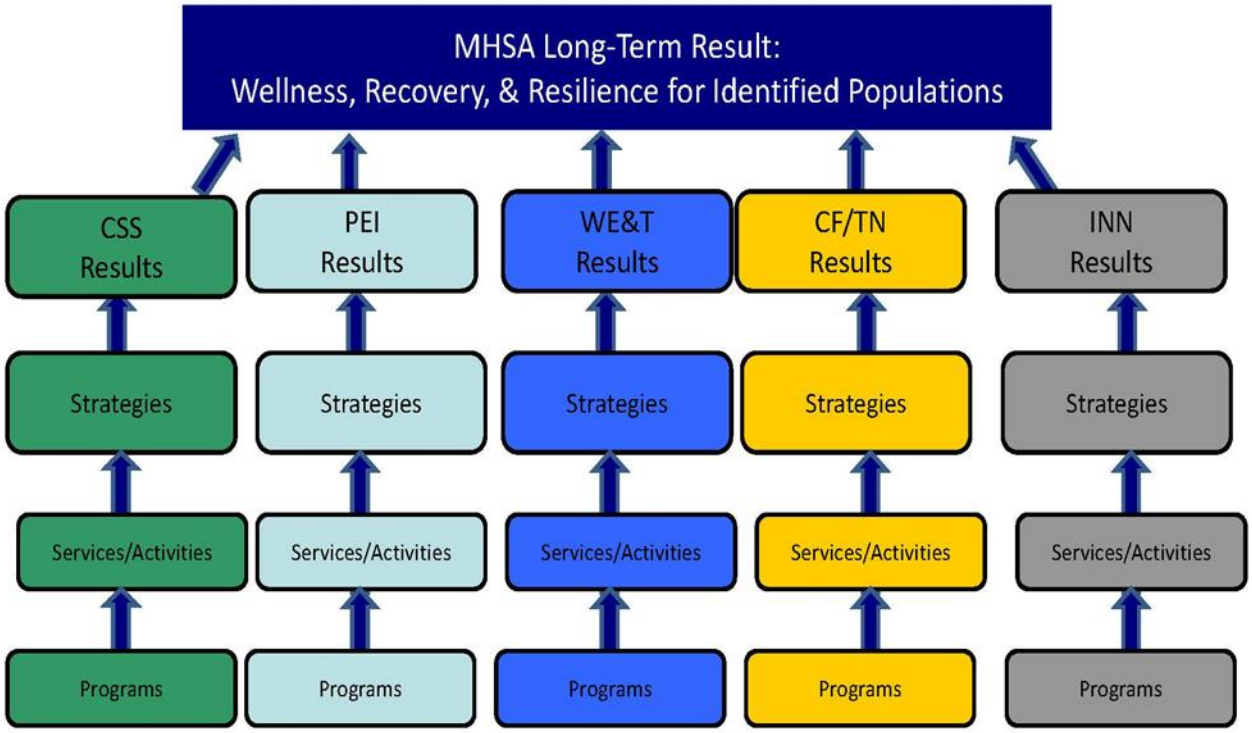
FY 2023-2024 Actual Results

This section reports actual results for programs and services that were funded by MHSA in FY 2023-2024.

Theory of Change – Results Based Accountability Framework

BHRS embraces the values of MHSA to improve behavioral health outcomes for those community members struggling with mental illness. The Department's goal is to transform the public behavioral health system with a long-term goal to create community outcomes that represent Wellness, Recovery and Resilience. To guide the efforts, BHRS uses the Theory of Change and Results Based Accountability (RBA) frameworks.

The Theory of Change is a road map for planning and evaluation to promote change. It defines long-term goals and desired outcomes. RBA is a methodology to develop, interpret, and present program results. BHRS utilizes the RBA framework to evaluate services and progress and to show how programs are impacting lives of those who are served.



Community Services and Supports

In FY 2023-2024, the programs outlined below were in operation. Actual program results for the individual programs are found on the following pages.

Full-Service Partnership (FSP) programs:

- FSP-01 Adult Behavioral Health Services Team
- FSP-02 Adult Medication Clinic
- FSP-03 Children and Transition Age Youth Behavioral Health Services Team

General System Development (GSD) programs:

- GSD-01 Adult Residential Facilities
- GSD-02 Residential Substance Use Disorder Board and Care
- GSD-03 Housing Placement Assistance
- GSD-04 Employment Support Services
- GSD-05 Behavioral Health Wellness Center
- GSD-06 Behavioral Health Crisis and Support Line
- GSD-07 Short Term Residential Therapeutic Programs
- GSD-08 Crisis Residential Unit
- GSD-09 Therapeutic Foster Care Services
- GSD-10 Portion of Adult Medication Clinic
- GSD-11 Central Valley Homes Development Project

Outreach and Engagement (O&E) programs:

- O&E-01 Behavioral Health Outreach and Engagement
- O&E-02 Assisted Outpatient Treatment
- O&E-03 Housing Support Services
- O&E-04 Garden Gate Respite
- O&E-05 Short-Term Shelter and Housing
- O&E-06 Homelessness Access Center Integration
- O&E-07 Community Assessment, Response, and Engagement

FSP 01 Adult Behavioral Health Services Team Model

Operated By: Telecare, Turning Point Community Programs, BHRS Turlock Center
System of Care: Adult System of Care (ASOC)

PROGRAM DESCRIPTION

The Adult Behavioral Health Services Team (BHST) structure aims to broaden access to services for members across programs by eliminating the current structure in which teams specialize with certain populations or treatment needs. All treatment teams would serve the range of populations that meet criteria such as criminal justice involved, homelessness, co-occurring SUDs, and high-risk health issues. BHSTs have levels of care to allow members to progress through the recovery process with support from a trusted behavioral health treatment team. By integrating levels of care in a team, the client can access higher or lower levels of services, while maintaining valuable therapeutic relationship within a team that uniquely understands the client's behavioral health needs and has developed a trusted relationship.

TARGET POPULATION

- Transitional Age Young (TAY) Adults – age range is 18-25. In FY 2023-2024 the estimated number of TAY to be served is 200.
- Adults – age range 26-59. In FY 2023-2024 the estimated number of adults to be served is 840.
- Older Adults – age 60+. In FY 2023-2024 the estimated number of TAY to be served is 160.

SERVICES AND ACTIVITIES

Services include 24/7 access to a known service provider, access to supportive service funds, individualized service planning, peer and family support, housing and employment assistance, independent living skills training, behavioral health rehabilitation, case management, therapy, medication support, and linkages to existing community supports.

Telecare Behavioral Health Services Team

Operated By: Telecare
System of Care: ASOC

PROGRAM DESCRIPTION

A multi-disciplinary program that provides comprehensive behavioral health and co-occurring services for adults (ages 18 and older) who as a result of serious and persistent mental illness have difficulty maintaining stable residence, experience significant inability to engage in productive activities and daily responsibilities or experience frequent or lengthy psychiatric hospitalization.

TARGET POPULATION

- Transitional Age Young (TAY) Adults – age range is 18-25. In FY 2023-2024 the estimated number of TAY to be served is 164.
- Adults – age range 26-59. In FY 2023-2024 the estimated number of adults to be served is 400.

- Older Adults – age 60+. In FY 2023-2024 the estimated number of TAY to be served is 50.

SERVICES AND ACTIVITIES

Services include 24/7 access to a known service provider, access to supportive service funds, individualized service planning, peer and family support, housing and employment assistance, independent living skills training, behavioral health rehabilitation, case management, therapy, medication support, and linkages to existing community supports.

Turning Point Community Programs Behavioral Health Services Team

Operated By: Turning Point Community Programs
System of Care: ASOC

PROGRAM DESCRIPTION

A multi-disciplinary program that provides comprehensive behavioral health and co-occurring services for adults (ages 18 and older) who as a result of serious and persistent mental illness have difficulty maintaining stable residence, experience significant inability to engage in productive activities and daily responsibilities or experience frequent or lengthy psychiatric hospitalization.

TARGET POPULATION

- Transitional Age Young (TAY) Adults – age range is 18-25. In FY 2023-2024 the estimated number of TAY to be served is 21.
- Adults – age range 26-59. In FY 2023-2024 the estimated number of adults to be served is 210.
- Older Adults – age 60+. In FY 2023-2024 the estimated number of TAY to be served is 80.

SERVICES AND ACTIVITIES

Services include 24/7 access to a known service provider, access to supportive service funds, individualized service planning, peer and family support, housing and employment assistance, independent living skills training, behavioral health rehabilitation, case management, therapy, medication support, and linkages to existing community supports.

BHRS Turlock Center Behavioral Health Services Team

Operated By: BHRS Turlock Center
System of Care: ASOC

PROGRAM DESCRIPTION

A multi-disciplinary program that provides comprehensive behavioral health and co-occurring services for adults (ages 18 and older) who as a result of serious and persistent mental illness have difficulty maintaining stable residence, experience significant inability to engage in productive activities and daily responsibilities, or experience frequent or lengthy psychiatric hospitalization.

TARGET POPULATION

- Transitional Age Young (TAY) Adults – age range is 18-25. In FY 2023-2024 the estimated number of TAY to be served is 15.
- Adults – age range 26-59. In FY 2023-2024 the estimated number of adults to be served is 230.
- Older Adults – age 60+. In FY 2023-2024 the estimated number of TAY to be served is 30.

SERVICES AND ACTIVITIES

Services include 24/7 access to a known service provider, access to supportive service funds, individualized service planning, peer and family support, housing and employment assistance, independent living skills training, behavioral health rehabilitation, case management, therapy, medication support, and linkages to existing community supports.

GSD FUNDED SERVICES

Not applicable.

FY 2023-2024 ACTUAL RESULTS:

In FY 2023-2024, the estimated number of individuals to be served is 1,200.

Future changes in the estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$3,549,240	1,797	$1,975

PARTICIPANT DEMOGRAPHICS:

Unique Client Counts FSP - BHST Telecare		
Race	Individuals Served FY 23/24	
	Number	Percentage
African American	**36**	**4%**
American Indian/ Alaskan Native	*	**1%**
Asian	*	**0%**
Filipino	*	**0%**
Guamanian	*	**0%**
Laotian	*	**0%**
Multiracial	**51**	**5%**
Other	**92**	**9%**
Pacific Islander	*	**1%**
Unknown	**505**	**52%**
White	**272**	**28%**
Total:	**977**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts FSP - BHST Telecare		
Ethnicity	Individuals Served FY 23/24	
Hispanic Origin	Number	Percentage
Yes	**396**	**41%**
No	**503**	**51%**
Unknown	**78**	**8%**
Total	**977**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts FSP - BHST Telecare		
Ages	Individuals Served FY 23/24	
	Number	Percentage
Child (0-15)	**0**	**0%**
TAY (16-25)	**338**	**35%**
Adult (26-59)	**564**	**58%**
Older Adult (60+)	**75**	**8%**
Unknown	**0**	**0%**
Total	**977**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts FSP - BHST Telecare		
Language	Individuals Served FY 23/24	
	Number	Percentage
English	**906**	**93%**
Spanish	**49**	**5%**
Other	*****	**<1%**
Unknown	**14**	**1%**
Total	**977**	**100%**

Due to privacy any value <10 has been removed

Data Sources:
SmartCare Data Warehouse for FY 2023-2024

Unique Client Counts FSP - BHST Turning Point		
Race	Individuals Served FY 23/24	
	Number	Percentage
African American	**16**	**3%**
American Indian/ Alaskan Native	*	**<1%**
Cambodian	*	**1%**
Guamanian	*	**<1%**
Laotian	*	**<1%**
Multiracial	**23**	**5%**
Other	**48**	**10%**
Pacific Islander	*	**<1%**
Unknown	**239**	**51%**
White	**134**	**29%**
Total:	**469**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts FSP - BHST Turning Point		
Ethnicity	Individuals Served FY 23/24	
Hispanic Origin	Number	Percentage
Yes	**133**	**28%**
No	**296**	**63%**
Unknown	**40**	**9%**
Total	**469**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts FSP - BHST Turning Point		
Ages	Individuals Served FY 23/24	
	Number	Percentage
Child (0-15)	**0**	**0%**
TAY (16-25)	**21**	**4%**
Adult (26-59)	**336**	**72%**
Older Adult (60+)	**112**	**24%**
Unknown	**0**	**0%**
Total	**469**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts FSP - BHST Turning Point		
Language	Individuals Served FY 23/24	
	Number	Percentage
English	**446**	**95%**
Spanish	**16**	**3%**
Other	*	**1%**
Unknown	*	**1%**
Total	**469**	**100%**

Due to privacy any value <10 has been removed

Data Sources:

- SmartCare Data Warehouse for FY 23/24

Unique Client Counts FSP - BHST Turlock		
Race	Individuals Served FY 23/24	
	Number	Percentage
African American	*	**2%**
American Indian/ Alaskan Native	*	**1%**
Asian	*	**<1%**
Filipino	*	**1%**
Laotian	*	**<1%**
Multiracial	**15**	**4%**
other	**49**	**14%**
Pacific Islander	*	**1%**
Unknown	**189**	**54%**
White	**82**	**23%**
Total:	**351**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts FSP - BHST Turlock		
Ethnicity	Individuals Served FY 23/24	
Hispanic Origin	Number	Percentage
Yes	**123**	**35%**
No	**185**	**53%**
Unknown	**43**	**12%**
Total	**351**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts FSP - BHST Turlock		
Ages	Individuals Served FY 23/24	
	Number	Percentage
Child (0-15)	**0**	**0%**
TAY (16-25)	**34**	**10%**
Adult (26-59)	**276**	**79%**
Older Adult (60+)	**41**	**12%**
Unknown	**0**	**0%**
Total	**351**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts FSP - BHST Turlock		
Language	Individuals Served FY 23/24	
	Number	Percentage
English	**312**	**89%**
Spanish	**20**	**6%**
Other	*****	**1%**
Unknown	**14**	**4%**
Total	**351**	**100%**

Data Sources:

- SmartCare Data Warehouse for FY 2023-2024

OUTCOMES:

MHSA Outcomes for FSP - BHST Telecare	
Outcomes	Number/Percentage FY 23/24
How Much?	
Individuals Served*	977
Average number of clinical services per individual*	43 41,668 / 977
Average number of support services per individual*	9 8,379 / 977
How Well?	
% of annual target of individuals served*	130% 977 / 750
Average length of FSP Service -- days*	423 413,269 / 977
% of surveyed individuals were satisfied with services**	88% 65 / 74
% of surveyed individuals said that "staff believed I could change"**	93% 66 / 71
Better Off?	
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	81% 57 / 70
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	61% 39 / 64
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	88% 369 / 420

Data Sources:
*SmartCare Data Warehouse for FY 2023-2024
**State Satisfaction survey results from May 2024 survey period May 20, 2024 - May 24, 2024.

FY 23/24 Outcomes for Partners After One Year in BHST Telecare # Completed at Least 1 Year = 527						
	Partners	1Yr. Prior	1Yr. Post	**Days**	1Yr. Prior	1Yr. Post
Homelessness	-18.0%	194	159	-19.3%	36,595	29,521
Incarcerations	-53.4%	58	27	-77.4%	5,837	1,321
Acute Medical Hospitalizations	-63.2%	38	14	-14.6%	226	193
Acute Psych Hospitalizations	-23.0%	165	127	21.8%	3,097	3,773
State Psychiatric	-80.0%	5	1	-99.9%	1,612	1

Data Sources:
State DCR Application with Enhanced Partnership Level Data program ran 8/30/2024 for FY 2023-2024.

How to read this table:

From left to right, reviewing Full-Service Partnership Residential data:
The first column provides residential categories reported.
The second column provides the percentage of individuals increase or decrease in residential status when comparing one year prior to enrollment and one-year post enrollment as well as the number of individuals reported in each category.

The third column indicates the percentage of increase or decrease in the number of days the individuals reported to be in a residential status when comparing one year prior to enrollment and one-year post enrollment, as well as the number of days reported in each category.
When the percentage is green or there is a minus symbol before the percentage, that indicates there was a decrease, which is a positive outcome. When the percentage is red it indicates a negative outcome for the partner.

MHSA Outcomes for FSP - BHST Turning Point	
Outcomes	Number/Percentage FY 23/24
How Much?	
Individuals Served*	469
Average number of clinical services per individual*	17 7,743 / 469
Average number of support services per individual*	7 3,295 / 469
How Well?	
% of annual target of individuals served*	134% 469 / 350
Average length of FSP Service -- days*	454 212,755 / 469
% of surveyed individuals were satisfied with services**	97% 33 / 34
% of surveyed individuals said that "staff believed I could change"**	94% 30 / 32
Better Off?	
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	80% 24 / 30
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	56% 18 / 32
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	86% 162 / 189

Data Sources:
*SmartCare Data Warehouse for FY 2023-2024.
**State Satisfaction survey results from May 2024 survey period May 20, 2024 - May 24, 2024.

FY 23/24 Outcomes for Partners After One Year in BHST Turning Point # Completed at Least 1 Year = 218						
	Partners	1Yr. Prior	1Yr. Post	**Days**	1Yr. Prior	1Yr. Post
Homelessness	-6.6%	91	85	-22.1%	16,979	13,221
Incarcerations	-63.6%	22	8	-62.9%	2,341	869
Acute Medical Hospitalizations	**0.0%**	26	26	-44.0%	822	460
Acute Psych Hospitalizations	-15.2%	66	56	99.3%	1,312	2,615
State Psychiatric	-100.0%	2	0	-100.0%	183	0

Data source:

- State DCR Application with Enhanced Partnership Level Data program ran 8/30/2024 for FY 2023-2024.

How to read this table:

From left to right, reviewing Full-Service Partnership Residential data:
The first column provides residential categories reported.
The second column provides the percentage of individuals increase or decrease in residential status when comparing one year prior to enrollment and one-year post enrollment as well as the number of individuals reported in each category.

The third column indicates the percentage of increase or decrease in the number of days the individuals reported to be in a residential status when comparing one year prior to enrollment and one-year post enrollment, as well as the number of days reported in each category.
When the percentage is green or there is a minus symbol before the percentage, that indicates there was a decrease, which is a positive outcome. When the percentage is red it indicates a negative outcome for the partner.

MHSA Outcomes for FSP - BHST Turlock	
Outcomes	Number/Percentage FY 23/24
How Much?	
Individuals Served*	351
Average number of clinical services per individual*	14 5,027 / 351
Average number of support services per individual*	6 2,180 / 351
How Well?	
% of annual target of individuals served*	100% 351 / 350
Average length of FSP Service -- days*	368 129,017 / 351
% of surveyed individuals were satisfied with services**	90% 38 / 42
% of surveyed individuals said that "staff believed I could change"**	86% 36 / 42
Better Off?	
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	76% 29 / 38
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	49% 19 / 39
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	86% 219 / 256

Data Sources:
*SmartCare Data Warehouse for FY 2023-2024.
**State Satisfaction survey results from May 2024 survey period May 20, 2024 - May 24, 2024.

FY23/24 Outcomes for Partners After One Year in BHST Turlock # Completed at Least 1 Year = 178						
	Partners	1Yr. Prior	1Yr. Post	**Days**	1Yr. Prior	1Yr. Post
Homelessness	74.2%	31	54	-4.9%	7,005	6,662
Incarcerations	8.3%	12	13	22.8%	553	679
Acute Medical Hospitalizations	**0.0%**	19	19	-29.2%	312	221
Acute Psych Hospitalizations	113.3%	30	64	99.3%	705	1,405
State Psychiatric	-66.7%	3	1	53.1%	196	300

Data source:

- State DCR Application with Enhanced Partnership Level Data program ran 8/30/2024 for FY 2023-2024.

How to read this table:

From left to right, reviewing Full-Service Partnership Residential data:
The first column provides residential categories reported.
The second column provides the percentage of individuals increase or decrease in residential status when comparing one year prior to enrollment and one-year post enrollment as well as the number of individuals reported in each category.

The third column indicates the percentage of increase or decrease in the number of days the individuals reported to be in a residential status when comparing one year prior to enrollment and one-year post enrollment, as well as the number of days reported in each category.
When the percentage is green or there is a minus symbol before the percentage, that indicates there was a decrease, which is a positive outcome. When the percentage is red it indicates a negative outcome for the partner.

FSP 02 Adult Medication Clinic

Operated By: Stanislaus County Behavioral Health and Recovery Services
System of Care: Medication Clinics

PROGRAM DESCRIPTION

The Adult Medication Clinic supports Behavioral Health Services Teams (BHSTs) by providing psychiatric consultation, evaluation, and treatment of BHRS members. Interventions provided include prescribing, administering, dispensing, and monitoring of psychotropic medications. Prescribers (psychiatrists and/or nurse practitioners) and nurses are part of the patient's interdisciplinary treatment team and help guide the course of a patient's treatment. Adult Medication Clinics are located in Modesto and Turlock.

TARGET POPULATIONS

- Transitional Age Young Adults – age range 18-25
- Adults – age range 26-59
- Older Adults – age 60+

SERVICES AND ACTIVITIES

The Adult Medication Clinic provides psychiatric consultation, evaluation, and treatment of members of BHRS and our community partners. Interventions include prescribing, administering, dispensing, and monitoring of psychotropic medications. The Clinic also provides consultation on non-medication related issues (e.g., medical-legal such as conservatorship) or other issues of concern to the treatment team. Clinic prescribers (psychiatrists and/or nurse practitioners) and nurses are part of the patient's interdisciplinary treatment team and help guide the course of a patient's treatment.

In FY 2023-2024, the estimated number of individuals to be served is 900.

GSD FUNDED SERVICES

Not applicable.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$932,630	1105	$844

PARTICIPANT DEMOGRAPHICS:

Unique Client Counts FSP Adult Medication Clinic		
Race	Individuals Served FY 23/24	
	Number	Percentage
African American	**33**	**3%**
Asian	*	**<1%**
Native American	*	**<1%**
Cambodian	*	**<1%**
Filipino	*	**<1%**
Guamanian	*	**<1%**
Laotian	*	**<1%**
Multiracial	**47**	**4%**
Other	**99**	**9%**
Other Pacific Islander	*	**<1%**
Unknown/Not Reported	**616**	**56%**
White	**292**	**26%**
Total:	**1105**	**100%**

*Due to privacy any value <10 has been removed

Unique Client Counts FSP Adult Medication Clinic		
Ethnicity	Individuals Served FY 23/24	
Hispanic Origin	Number	Percentage
Yes	**398**	**36%**
No	**628**	**57%**
Unknown	**79**	**7%**
Total	**1105**	**100%**

Unique Client Counts FSP Adult Medication Clinic		
Ages	Individuals Served FY 23/24	
	Number	Percentage
Child (0-15)	**0**	**0%**
TAY (16-25)	**228**	**21%**
Adult (26-59)	**732**	**66%**
Older Adult (60+)	**145**	**13%**
Unknown	**0**	**0%**
Total	**1105**	**100%**

Unique Client Counts FSP Adult Medication Clinic		
Language	Individuals Served FY 23/24	
	Number	Percentage
English	**1022**	**92%**
Spanish	**58**	**5%**
Other	*	**1%**
Unknown	**18**	**2%**
Total	**1105**	**100%**

*Due to privacy any value <10 has been removed

Data Sources:
SmartCare Data Warehouse for FY 2023-2024.

OUTCOMES:

MHSA Outcomes for FSP - Adult Medication Clinic	
Outcomes	Number/Percentage FY 23/24
How Much?	
Individuals Served*	1105
Average number of clinical services per Individual*	8 8,987 / 1105
Average number of support services per Individual*	0 339 / 1105
How Well?	
% of annual target of individuals served*	123% 1105 / 900
Average length of FSP Service -- days*	705 778,609 / 1105
% of surveyed individuals were satisfied with services**	96% 26 / 27
% of surveyed individuals said that "staff believed I could change"**	96% 26 / 27
Better Off?	
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	73% 19 / 26
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	72% 18 / 25
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	87% 140 / 161

Data Sources:
*SmartCare Data Warehouse for FY 2023-2024.
**State Satisfaction survey results from May 2024 survey period May 20, 2024 - May 24, 2024.

FSP-03 Children and Transition Age Youth Behavioral Health Services Team

Operated By: Central Star & Sierra Vista Child and Family Services
System of Care: Children System of Care (CSOC)

PROGRAM DESCRIPTION

The Children and Transition Age Youth Behavioral Health Service Team (BHST) provides core treatment services for children and youth who are at risk for out of home placement in publicly funded care, such as resource families, Short Term Residential Therapeutic Programs (STRTPs), correctional institutions or psychiatric facilities due to emotional, social and/or behavioral problems. The goal of these services is to improve the child's overall functioning within their family, school, peer group and community; reduce risk and incidence of behavioral health disability; and improve family well-being and functioning. Children and youth who are at acute risk for disruption in home or school placement, or for incarceration or psychiatric hospitalization, will receive a team based, "full-service partnership" (FSP) approach, that includes a Child and Family Team (CFT) made up of the child or youth, family members, professional, peer, and natural supports. Peer support is integrated into the team to support caregivers or youth. Services and supports are available 24 hours a day, 7 days a week. Within the FSP team structure is an Assertive Community Treatment (ACT) level and an Intensive Community Support (ICS) level to ensure that the child or youth receives services based on the intensity and frequency determined through the CFT process.

TARGET POPULATION

- Children and Youth – age range 0 to 15. In FY 2023-2024 the estimated number of Children and Youth to be served is 210.
- Transitional Age Young Adults – age range is 16-25. In FY 2023-2024 the estimated number of TAY to be served is 115.

SERVICES AND ACTIVITIES

The BHSTs provide covered Specialty Mental Health Services (SMHS) for beneficiaries who have experienced crisis, psychiatric hospitalization, incarceration, homelessness, or symptoms and behaviors that may increase the risk for out of home placement. Services include the following behavioral health services: individual and group therapy, family counseling, targeted case management, individual and group rehabilitation, intensive care coordination (ICC), intensive home-based services (IHBS), and crisis intervention. Services are individualized and services are available 24 hours a day, 7 days a week. Services are provided in the location needed for the individual and are provided from a "whatever it takes" approach, in partnership with the individual and family.

GSD FUNDED SERVICES

Not applicable.

FY 2023-2024 ACTUAL RESULTS:

In FY 2023-2024, the estimated number of individuals to be served is 325.

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$1,489,053	431	$3,455

PARTICIPANT DEMOGRAPHICS:

Unique Client Counts FSP - Central Star BHST		
Race	Individuals Served FY 23/24	
	Number	Percentage
African American	*	3%
Asian	*	<1%
Multiracial	*	5%
Other	26	12%
Unknown	94	43%
White	81	37%
Total:	218	100%

Due to privacy any value <10 has been removed

Unique Client Counts FSP Central Star BHST		
Ethnicity	Individuals Served FY 23/24	
Hispanic Origin	Number	Percentage
Yes	104	48%
No	69	32%
Unknown	45	21%
Total	218	100%

Due to privacy any value <10 has been removed

Unique Client Counts FSP Central Star BHST		
Ages	Individuals Served FY 23/24	
	Number	Percentage
Child (0-15)	157	72%
TAY (16-25)	61	28%
Adult (26-59)	0	0%
Older Adult (60+)	0	0%
Unknown	0	0%
Total	218	100%

Due to privacy any value <10 has been removed

Unique Client Counts FSP Central Star BHST		
Language	Individuals Served FY 23/24	
	Number	Percentage
English	**181**	**83%**
Spanish	**22**	**10%**
Other	*	**<1%**
Unknown	**14**	**6%**
Total	**218**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts FSP - Sierra Vista Child & Family Services BHST		
Race	Individuals Served FY 23/24	
	Number	Percentage
African American	*	**3%**
Asian	*	**<1%**
American Indian/ Alaskan Native	*	**<1%**
Multiracial	**14**	**7%**
Other	**54**	**25%**
Unknown	**72**	**34%**
White	**64**	**30%**
Total:	**213**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts FSP Sierra Vista Child & Family Services BHST		
Ethnicity	Individuals Served FY 23/24	
Hispanic Origin	Number	Percentage
Yes	**127**	**60%**
No	**70**	**33%**
Unknown	**16**	**8%**
Total	**213**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts FSP Sierra Vista Child & Family Services BHST		
Ages	Individuals Served FY 23/24	
	Number	Percentage
Child (0-15)	**148**	**69%**
TAY (16-25)	**65**	**31%**
Adult (26-59)	**0**	**0%**
Older Adult (60+)	**0**	**0%**
Unknown	**0**	**0%**
Total	**213**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts FSP Sierra Vista Child & Family Services BHST		
Language	Individuals Served FY 23/24	
	Number	Percentage
English	**184**	**86%**
Spanish	**27**	**13%**
Other	**0**	**0%**
Unknown	*****	**1%**
Total	**213**	**100%**

Due to privacy any value <10 has been removed

Data Sources:

- SmartCare Data Warehouse for FY 2023-2024.

OUTCOMES:

MHSA Outcomes for FSP - Central Star BHST	
Outcomes	Number/Percentage FY 23/24
How Much?	
Individuals Served*	218
Average number of clinical services per individual*	29 6,223 / 218
Average number of support services per individual*	8 1,746 / 218
How Well?	
% of annual target of individuals served*	109% 218 / 200
Average length of FSP Service -- days*	165 36,075 / 218
% of surveyed individuals were satisfied with services**	91% 10 / 11
% of surveyed individuals said that "staff believed I could change"**	100% 11 / 11
Better Off?	
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	91% 10 / 11
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	100% 9 / 9
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	95% 21 / 22

Data Sources:
*SmartCare Data Warehouse for FY 2023-2024.
**State Satisfaction survey results from May 2024 survey period May 20, 2024 - May 24, 2024.

FY23/24 Outcomes for Partners After One Year in Central Star # Completed at Least 1 Year = 36						
	Partners	1Yr. Prior	1Yr. Post	**Days**	1Yr. Prior	1Yr. Post
Homelessness	**	0	1	**	0	216
Incarcerations	0.0%	0	0	0.0%	0	0
Acute Medical Hospitalizations	0.0%	0	0	0.0%	0	0
Acute Psych Hospitalizations	11.1%	9	10	163.8%	160	422
State Psychiatric	0.0%	0	0	0.0%	0	0

** Value cannot be measured because no prior data is available for comparison.
Data source:

- State DCR Application with Enhanced Partnership Level Data program ran 8/30/2024 for FY 2023-2024.

How to read this table:

From left to right, reviewing Full-Service Partnership Residential data:
The first column provides residential categories reported.
The second column provides the percentage of individuals increase or decrease in residential status when comparing one year prior to enrollment and one-year post enrollment as well as the number of individuals reported in each category.

The third column indicates the percentage of increase or decrease in the number of days the individuals reported to be in a residential status when comparing one year prior to enrollment and one-year post enrollment, as well as the number of days reported in each category.
When the percentage is green or there is a minus symbol before the percentage, that indicates there was a decrease, which is a positive outcome. When the percentage is red it indicates a negative outcome for the partner.

MHSA Outcomes for FSP Sierra Vista Child & Family Services BHST	
Outcomes	Number/Percentage FY 23/24
How Much?	
Individuals Served*	213
Average number of clinical services per individual*	30 6,442 / 213
Average number of support services per individual*	7 1,418 / 213
How Well?	
% of annual target of individuals served*	170% 213 / 125
Average length of FSP Service -- days*	231 49,239 / 213
% of surveyed individuals were satisfied with services**	93% 52 / 56
% of surveyed individuals said that "staff believed I could change"**	98% 55 / 56
Better Off?	
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	71% 41 / 58
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	93% 52 / 56
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	90% 103 / 114

Data Sources:
*SmartCare Data Warehouse for FY 2023-2024.
**State Satisfaction survey results from May 2024 survey period May 20, 2024 - May 24, 2024.

FY 23/24 Outcomes for Partners After One Year in SVCFS # Completed at Least 1 Year = 65						
	Partners	1Yr. Prior	1Yr. Post	**Days**	1Yr. Prior	1Yr. Post
Homelessness	-50.0%	2	1	25.9%	290	365
Incarcerations	**	0	1	**	0	128
Acute Medical Hospitalizations	100.0%	1	2	-69.6%	23	7
Acute Psych Hospitalizations	36.4%	11	15	159.8%	199	517
State Psychiatric	-100.0%	1	0	-100.0%	10	0

** Value cannot be measured because no prior data is available for comparison.
Data source:

- State DCR Application with Enhanced Partnership Level Data program ran 8/30/2024 for FY 2023-2024

How to read this table:

From left to right, reviewing Full-Service Partnership Residential data:
The first column provides residential categories reported.
The second column provides the percentage of individuals increase or decrease in residential status when comparing one year prior to enrollment and one-year post enrollment as well as the number of individuals reported in each category.

The third column indicates the percentage of increase or decrease in the number of days the individuals reported to be in a residential status when comparing one year prior to enrollment and one-year post enrollment, as well as the number of days reported in each category.
When the percentage is green or there is a minus symbol before the percentage, that indicates there was a decrease, which is a positive outcome. When the percentage is red it indicates a negative outcome for the partner.

O&E-01 Behavioral Health Outreach and Engagement

Operated By: BHOE
System of Care: Adult System of Care (ASOC)

PROGRAM DESCRIPTION

The Behavioral Health Outreach and Engagement (BHOE) provides outreach, engagement and linkages to unserved/underserved adult individuals who may need or request specialty behavioral health services and are identified as not currently receiving needed outpatient treatment. BHOE is comprised of two program tracks: Community Outreach and Linkages and Inpatient Psychiatric Hospital Liaison services. The team includes Behavioral Health Specialists, Behavioral Health Clinicians, Peer Specialists and Family Advocates.

- Community Outreach and Linkage Services: To unserved/underserved adults in the community, who may request or be referred for linkages to voluntary specialty behavioral health and substance use disorder services. Referrals are received from within county departments, the community, co-location partnership with the County Access Center and serving the Assisted Outpatient Treatment program AB 1421- Does Not Meet Statutory criteria segment, who are offered up to 90 days of supportive linkages. For those who do not meet Screening criteria for specialty behavioral health services, the BHOE team provides linkages to their community health care plan and community resources.

- Inpatient Psychiatric Hospital Liaison Services: To unserved/underserved adults placed on a psychiatric involuntary legal status, at local or out- of county diversion inpatient psychiatric hospitals, who may request or be referred for BHOE Liaison linkages to link to outpatient specialty behavioral health and substance use disorder services. BHOE Liaisons provide pre-discharge linkages to specialty behavioral health and or SUD services, with engagement and referrals to BHOE Behavioral Health Clinicians, whose Urgent Behavioral Health Assessments link to an outpatient treatment services, prior to discharge. BHOE also links individuals placed on a Temporary Conservatorship while hospitalized.

TARGET POPULATION (Within Stanislaus County)

- Transitional Age Young Adults – age range is 18-25.
- Adults – age range 26-59
- Older Adults – age 60+

SERVICES AND ACTIVITIES

BHOE services include proactive outreach services in community and inpatient psychiatric hospitals with the aim of building trusting relationships, implementing coordinated individualized intervention plans, and connecting individuals directly to treatment and supportive services. BHOE has services providers that provide outreach and engagement, case management, behavioral health screening/assessment, psychoeducation, behavioral health services navigation and referrals, and case-by-case transportation to help with access to services and/or community supports.

In FY 2023-2024, the estimated number of individuals to be served is 1200.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$1,031,397	1657	$622

PARTICIPANT DEMOGRAPHICS:

Unique Client Counts O&E - Behavioral Health Outreach and Engagement (BHOE)		
Race	Individuals Served FY 23/24	
	Number	Percentage
African American	**72**	**4%**
Asian	**14**	**1%**
American Indian/ Alaskan Native	**19**	**1%**
Cambodian	*	**<1%**
Filipino	*	**<1%**
Laotian	*	**<1%**
Multiracial	**43**	**3%**
Native Hawaiian	*	**<1%**
Other	**174**	**11%**
Pacific Islander	*	**<1%**
Unknown	**734**	**44%**
Vietnamese	*	**<1%**
White	**578**	**35%**
Total:	**1,657**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts O&E - Behavioral Health Outreach and Engagement (BHOE)		
Ethnicity	Individuals Served FY 23/24	
Hispanic Origin	Number	Percentage
Yes	**407**	**25%**
No	**655**	**40%**
Unknown	**595**	**36%**
Total	**1,657**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts O&E - Behavioral Health Outreach and Engagement (BHOE)		
Ages	Individuals Served FY 23/24	
	Number	Percentage
Child (0-15)	*	<1%
TAY (16-25)	256	15%
Adult (26-59)	1245	75%
Older Adult (60+)	155	9%
Unknown	0	0%
Total	**1,657**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts O&E - Behavioral Health Outreach and Engagement (BHOE)		
Language	Individuals Served FY 23/24	
	Number	Percentage
English	1,466	88%
Spanish	55	3%
Other	20	1%
Unknown	116	7%
Total	**1,657**	**100%**

Due to privacy any value <10 has been removed

Data Sources:

- SmartCare Data Warehouse for FY 2023-2024.

OUTCOMES:

MHSA Outcomes for O&E - Behavioral Health Outreach and Engagement (BHOE)	
Outcomes	Number/Percentage FY 23/24
How Much?	
Individuals Served*	1657
Average number of clinical services per individual*	6 298 / 1657
Average number of support services per individual*	2 3,187 / 1657
How Well?	
% of annual target of individuals served*	138% 1657 / 1200
Average length of O&E Service -- days*	111 184,374 / 1657
% of surveyed individuals were satisfied with services**	No Surveys Received
% of surveyed individuals said that "staff believed I could change"**	No Surveys Received
Better Off?	
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	No Surveys Received
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	No Surveys Received
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	No Surveys Received

Data Sources:
*SmartCare Data Warehouse for FY 2023-2024
**State Satisfaction survey results from May 2024 survey period May 20, 2024 - May 24, 2024.

O&E-02 Assisted Outpatient Treatment

Operated By: Stanislaus County Behavioral Health and Recovery Services
System of Care: ASOC

PROGRAM DESCRIPTION

Assisted Outpatient Treatment (AOT) – is a Civil court-ordered treatment for individuals with severe and persistent mental illness who meet strict legal criteria. Often, these individuals experience severe behavioral health symptoms which impact their ability to recognize the need for treatment. AOT allows for a Qualified Referring Party (QRP) to refer an individual for behavioral health treatment without the consent of the individual. The AOT Team connects with the QRP and the individual to assess for SMI, their level of engagement, and their risk. Individuals are referred to an appropriate BHRS team while the AOT team continues to assist with engagement and assess for appropriateness for the court-ordered treatment.

TARGET POPULATION

- TAY Adults – age range is 18-25.
- Adults – age range 26-59
- Older Adults – age 60+

SERVICES AND ACTIVITIES

The AOT Outreach and Engagement program provides intensive outreach services that seek to engage, assess, and refer individuals with serious mental illness to BHRS services and community supports. Outreach services include family advocacy services, behavioral health screening/assessment, psychoeducation, behavioral health services navigation and referrals, and transportation to help with access to services and/or community supports. The AOT program utilizes the Assertive Community Treatment (ACT) approach including, but not limited to, 24 hours, 7 days per week access to a known service provider, intensive community-based services, low client to staff caseload ratio, access to supportive service funds to assist with housing and basic needs, and a 'housing first' approach.

In FY 2023-2024, the estimated number of individuals to be served is 80.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$1,031,397	137	$7,528

PARTICIPANT DEMOGRAPHICS:

Unique Client Counts O&E - Assisted Outpatient Treatment (AOT)		
Race	Individuals Served FY 23/24	
	Number	Percentage
African American	*	4%
American Indian/ Alaskan Native	*	1%
Asian	*	2%
Laotian	*	1%
Multiracial	*	1%
Other	15	11%
Unknown	64	47%
White	46	34%
Total:	137	100%

Due to privacy any value <10 has been removed

Unique Client Counts O&E - Assisted Outpatient Treatment (AOT)		
Ethnicity	Individuals Served FY 23/24	
Hispanic Origin	Number	Percentage
Yes	45	33%
No	74	54%
Unknown	18	13%
Total	137	100%

Due to privacy any value <10 has been removed

Unique Client Counts O&E - Assisted Outpatient Treatment (AOT)		
Ages	Individuals Served FY 23/24	
	Number	Percentage
Child (0-15)	0	0%
TAY (16-25)	25	18%
Adult (26-59)	95	69%
Older Adult (60+)	17	12%
Unknown	0	0%
Total	137	100%

Due to privacy any value <10 has been removed

Unique Client Counts O&E - Assisted Outpatient Treatment (AOT)		
Language	Individuals Served FY 23/24	
	Number	Percentage
English	**130**	**95%**
Spanish	*	**3%**
Other	*	**1%**
Unknown	*	**1%**
Total	**137**	**100%**

Due to privacy any value <10 has been removed

Data Sources:
SmartCare Data Warehouse for FY 2023-2024

OUTCOMES:

MHSA Outcomes for O&E - Assisted Outpatient Treatment (AOT)	
Outcomes	Number/Percentage FY 23/24
How Much?	
Individuals Served*	137
Average number of clinical services per individual*	0 32 / 137
Average number of support services per individual*	4 516 / 137
How Well?	
% of annual target of individuals served*	171% 137 / 80
Average length of O&E Service -- days*	672 92,107 / 137
% of surveyed individuals were satisfied with services**	No Surveys Received
% of surveyed individuals said that "staff believed I could change"**	No Surveys Received
Better Off?	
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	No Surveys Received
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	No Surveys Received
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	No Surveys Received

Data Sources:
*SmartCare Data Warehouse for FY 2023-2024
**State Satisfaction survey results from May 2024 survey period May 20, 2024 - May 24, 2024.

O&E-03 Housing Support Services

Operated By: Stanislaus County Behavioral Health and Recovery Services
System of Care: Supportive Services Division (SSD)

PROGRAM DESCRIPTION

Housing Support Services provides an array of support services for individuals facing barriers that include low income, severe mental illness, substance abuse, and other disabling conditions. The program offers a combination of affordable housing and support services designed to help individuals and families use housing as a platform for wellness and recovery following a period of homelessness, hospitalization or incarceration. The goal of Housing Support Services is to assist individuals in obtaining Housing stability, independent living skills, employment, recovery and increased self-sufficiency.

TARGET POPULATION

- TAY Adults – age range is 18-25.
- Adults – age range 26-59
- Older Adults – age 60+

SERVICES AND ACTIVITIES

Housing supportive services includes all supports to assist individuals in maintaining independent living in the community. This can include but not limited to budgeting, paying bills, grocery shopping, cooking, how to get along with neighbors, how to maintain sobriety, coping skills, socialization skills, etc.

In FY 2023-2024, the estimated number of individuals to be served is 400.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$1,590,408	385	$4,131

PARTICIPANT DEMOGRAPHICS:

Unique Client Counts O&E Housing and Support Services		
Race	Individuals Served FY 23/24	
	Number	Percentage
African American	**24**	**6%**
Asian/Pacific Islander	*	**0%**
American Indian/ Alaska Native	*	**1%**
Filipino	*	**0%**
Multiracial	**19**	**5%**
Other	**27**	**7%**
Pacific Islander	*	**0%**
Unknown	**200**	**52%**
White	**109**	**28%**
Total:	**385**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts O&E Housing and Support Services		
Ethnicity	Individuals Served FY 23/24	
Hispanic Origin	Number	Percentage
Yes	**106**	**28%**
No	**253**	**66%**
Unknown	**26**	**7%**
Total	**385**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts O&E Housing and Support Services		
Ages	Individuals Served FY 23/24	
	Number	Percentage
Child (0-15)	**0**	**0%**
TAY (16-25)	**14**	**4%**
Adult (26-59)	**323**	**84%**
Older Adult (60+)	**48**	**12%**
Unknown	**0**	**0%**
Total	**385**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts O&E Housing and Support Services		
Language	Individuals Served FY 23/24	
	Number	Percentage
English	**373**	**97%**
Spanish	*	**1%**
Other	*	**0%**
Unknown	*	**2%**
Total	**385**	**100%**

Due to privacy any value <10 has been removed

Data Sources:
SmartCare Data Warehouse for FY 2023-2024

OUTCOMES:

MHSA Outcomes for O & E Housing and Support Services	
Outcomes	Number/Percentage FY 23/24
How Much?	
Individuals Served*	385
Average number of clinical services per individual*	0 51 / 385
Average number of support services per individual*	7 2,609 / 385
How Well?	
% of annual target of individuals served*	100% 385 / 385
Average length of O&E Service -- days*	896 344,933 / 385
% of surveyed individuals were satisfied with services**	No Surveys Received
% of surveyed individuals said that "staff believed I could change"**	No Surveys Received
Better Off?	
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	No Surveys Received
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	No Surveys Received
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	No Surveys Received

Data Sources:
*SmartCare Data Warehouse for FY 2023-2024
**State Satisfaction survey results from May 2024 survey period May 20, 2024 - May 24, 2024.

O&E-04 Garden Gate Respite

Operated By: Turning Point Community Programs
System of Care: SSD

PROGRAM DESCRIPTION

Garden Gate Respite (GGR) is an 11-bed facility open 24-hours a day, seven days a week, 365 days a year. It is a short-term residential program based on a "Harm Reduction" model for individuals who may be in crisis and in need of immediate shelter intervention and support services. Resources and linkages are provided such as behavioral health and SUD assessments, MH/SUD treatment, housing, case management, etc. BHRS, their contractors, and all local law enforcement agencies are the primary referral source. All individuals referred should have a perceived serious mental illness.

TARGET POPULATION

- Transitional Age Young Adults – age range is 18-25.
- Adults – age range 26-59
- Older Adults – age 60+
-

SERVICES AND ACTIVITIES

GGR provides food, clothing, and shelter in a safe home-like environment to engage SMI homeless individuals into services through a need's assessment. GGR provides on-site peer support, case management, linkage services and coordinates access to behavioral health, SUD and community resources. Peer support, and groups are offered to individuals staying at the facility.

In FY 2023-2024, the estimated number of individuals to be served is 300.

Because GGR is designed to be utilized as an engagement strategy the program is meant to be used repeatedly as needed for engagement; The total number served during this timeframe was 379, the 109 return admissions were accrued by 74 individuals.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$1,126,559	354	$3,182

PARTICIPANT DEMOGRAPHICS:

Unique Client Counts O&E Garden Gate Respite		
Race	Individuals Served FY 23/24	
	Number	Percentage
African American	**36**	**10%**
Asian/Pacific Islander	*****	**2%**
American Indian/ Alaska Native	**25**	**7%**
Multiracial	**14**	**4%**
Other	**35**	**10%**
Unknown	**20**	**6%**
White	**218**	**62%**
Total:	**354**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts O&E Garden Gate Respite		
Ethnicity	Individuals Served FY 23/24	
Hispanic Origin	Number	Percentage
Yes	**117**	**33%**
No	**211**	**60%**
Unknown	**26**	**7%**
Total	**354**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts O&E Garden Gate Respite		
Ages	Individuals Served FY 23/24	
	Number	Percentage
Child (0-15)	**0**	**0%**
TAY (16-25)	**15**	**4%**
Adult (26-59)	**284**	**80%**
Older Adult (60+)	**45**	**13%**
Unknown	**10**	**3%**
Total	**354**	**100%**

Due to privacy any value <10 has been removed

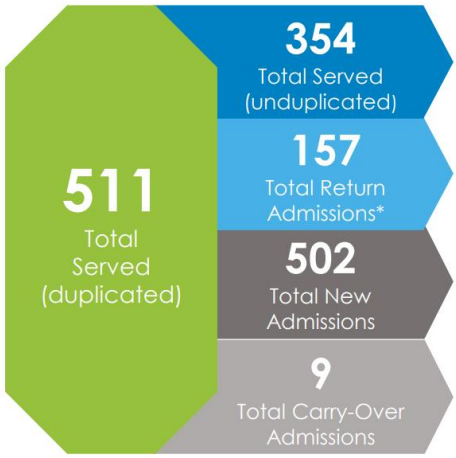
Unique Client Counts O&E Garden Gate Respite		
Language	Individuals Served FY 23/24	
	Number	Percentage
English	339	96%
Spanish	*	1%
Unknown	10	3%
Total	354	100%

Due to privacy any value <10 has been removed

Data Sources:
Garden Gate Respite (GGR) Annual Report for FY 2023-2024

OUTCOMES:

HOW MUCH?

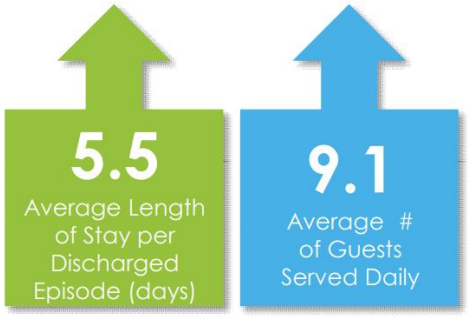


*The 157 return admissions were accrued by 96 individuals.

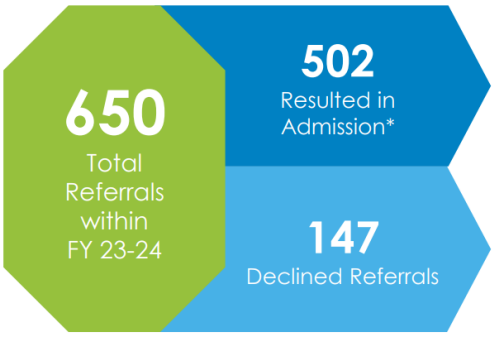
HOW WELL:

GOAL:
A minimum of 300 clients will receive respite services and support services.

ACTUAL:
502 enrollments took place within the fiscal year.



REFERRALS

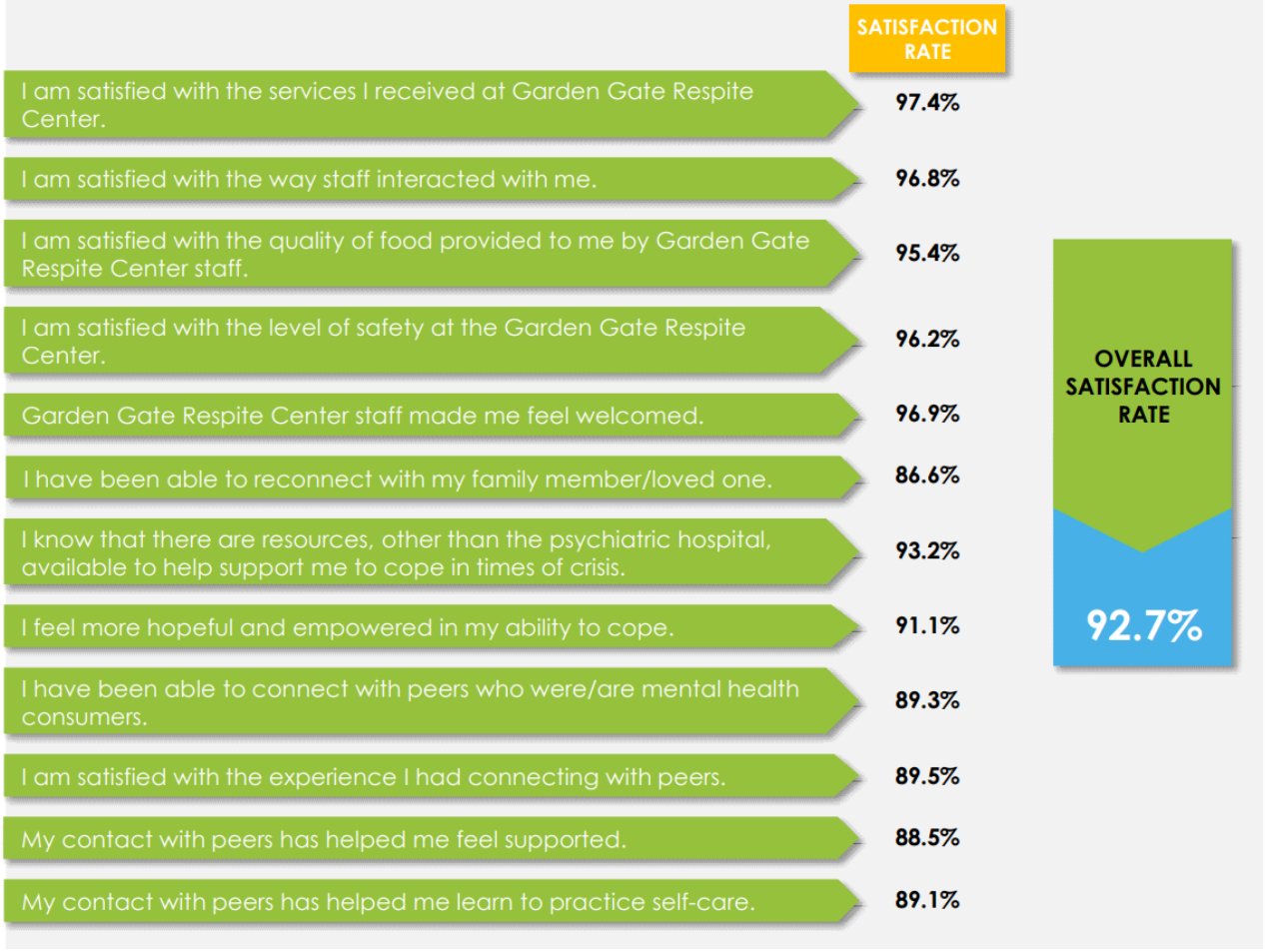


*10 (2.0%) of these were non-residing guests. Non-residing guests are those who were admitted to the program but did not stay overnight.

BETTER OFF:

CLIENT SATISFACTION SURVEYS

Client surveys are distributed at discharge in order to obtain information on individual's experiences at GGR. Out of 512 clients served during FY 23-24, 511 were discharged within that timeframe. Of 495 surveys administered, 164 (33.1%) were completed.



Data Sources:
Garden Gate Respite (GGR) ANNUAL REPORT July 2023 – June 2024

O&E-05 Short-Term Shelter and Housing

Operated By: Center for Human Services (CHS)
System of Care: SSD

PROGRAM DESCRIPTION
Short-Term Shelter and Housing is a Partnership with community shelters to provide overnight sleeping accommodations with the primary purpose of providing temporary shelter for BHRS members experiencing a housing crisis or as part of a treatment plan.

TARGET POPULATION
- TAY Adults – age range is 18-25.
- Adults – age range 26-59
- Older Adults – age 60+

SERVICES AND ACTIVITIES
Services include temporary shelter nights for individuals and/or families experiencing homelessness. Information and referrals to community resources are provided.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$42,218	71	$595

PARTICIPANT DEMOGRAPHICS:

Unique Client Counts: O&E - Short-Term Shelter and Housing		
Race	Individuals Served FY 23/24	
	Number	Percentage
African American	*	8%
Asian	*	1%
Multiracial	*	4%
Other	*	7%
Unknown	31	44%
White	25	35%
Total:	71	100%

Due to privacy any value <10 has been removed

Unique Client Counts: O&E - Short-Term Shelter and Housing		
Ethnicity	Individuals Served FY 23/24	
Hispanic Origin	Number	Percentage
Yes	20	28%
No	42	59%
Unknown	*	13%
Total	71	100%

Due to privacy any value <10 has been removed

Unique Client Counts: O&E - Short-Term Shelter and Housing		
Ages	Individuals Served FY 23/24	
	Number	Percentage
Child (0-15)	0	0%
TAY (16-25)	*	6%
Adult (26-59)	57	80%
Older Adult (60+)	*	13%
Unknown	*	1%
Total	71	100%

Due to privacy any value <10 has been removed

Unique Client Counts: O&E - Short-Term Shelter and Housing		
Language	Individuals Served FY 23/24	
	Number	Percentage
English	**64**	**90%**
Spanish	*	**3%**
Unknown	*	**7%**
Total	**71**	**100%**

Due to privacy any value <10 has been removed

Data Sources:

- SmartCare Data Warehouse for FY 2023-2024

OUTCOMES:

MHSA Outcomes for CHSS	
Outcomes	Number/Percentage FY 23/24
How Much?	
Individuals Served*	71
Average number of clinical services per individual*	68 4,812 71
Average number of support services per individual*	34 2,449 / 71
How Well?	
% of annual target of individuals served*	100% 71 71
Average Length of Service Days	1279 90,801 / 71
% of surveyed individuals were satisfied with services**	No Surveys Received
% of surveyed individuals said that "staff believed I could change"**	No Surveys Received
Better Off?	
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	No Surveys Received
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	No Surveys Received
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	No Surveys Received

O&E-06 Homelessness Access Center Integration

Operated By: Community Services Agency (CSA)/Turning Point Community Programs
System of Care: SSD

PROGRAM DESCRIPTION
The Homelessness Access Center Integration is an Agreement with other Stanislaus County departments for operational support of the Homeless Access Center. The Access Center is a "one stop" shop where coordinated services are provided along with critical housing interventions to help reduce homelessness.

TARGET POPULATION
- TAY Adults – age range is 18-25.
- Adults – age range 26-59
- Older Adults – age 60+

SERVICES AND ACTIVITIES
Community coordination and supports for housing assessments, referrals. public benefits, ID Vouchers/vital documents, SSI/SSDI services, etc.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$117,639	2832	$42

PARTICIPANT DEMOGRAPHICS:

Unique Client Counts: Homelessness Access Center Integration		
Ethnicity	Individuals Served FY 23/24	
	Number	Percentage
African American	**402**	**14%**
Asian	**42**	**1%**
Hispanic	**1272**	**45%**
Native American	**44**	**2%**
Other	**146**	**5%**
Pacific Islander	**36**	**1%**
Unknown	**2**	**0%**
White	**888**	**31%**
Total:	**2832**	**100%**

Unique Client Counts: Homelessness Access Center Integration		
Ages	Individuals Served FY 23/24	
	Number	Percentage
Child (0-15)	**875**	**31%**
TAY (16-25)	**279**	**10%**
Adult (26-59)	**1348**	**48%**
Older Adult (60+)	**330**	**12%**
Total	**2832**	**100%**

Unique Client Counts: Homelessness Access Center Integration		
Language	Individuals Served FY 23/24	
	Number	Percentage
English	**171**	**6%**
Spanish	**367**	**13%**
Other	**2**	**0%**
Unknown	**2292**	**81%**
Total	**2832**	**100%**

OUTCOMES:

MHSA Outcomes for Homelessness Access Center Integration	
Outcomes	Number/Percentage FY 23/24
How Much?	
Individuals Served*	2832
How Well?	
% of annual target of individuals served*	116% 2832 / 2450
% of surveyed individuals were satisfied with services**	No Surveys Received
% of surveyed individuals said that "staff believed I could change"**	No Surveys Received
Better Off?	
Individuals exited program into permanent living situations.	338
Individuals connected to Mental Health Services	124
Individuals assisted in completing Mainstream Housing Voucher application and submitting to Housing Authority	177
Individuals assisted in obtaining vital documents needed to be housing ready	775
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	No Surveys Received
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	No Surveys Received
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	No Surveys Received
Other Data Collected	
Individuals self-report having a Mental Health Disorder	927
Individuals self-report having alcohol use disorder, a drug use disorder, or both an alcohol and drug use disorder	357
Individuals self-report having developmental disability.	496
Individuals self-report history of domestic violence, sexual assault, dating violence, stalking or human trafficking	606
Individuals self-report history of domestic violence, sexual assault, dating violence, stalking or human trafficking within the last year	202

Data Sources:

*SmartCare Data Warehouse for FY 2023-2024

**State Satisfaction survey results from May 2024 survey period May 20, 2024 - May 24, 2024.

O&E-07 Community Assessment, Response, and Engagement

Operated By: Telecare
System of Care: ASOC

PROGRAM DESCRIPTION

CARE is a multidisciplinary team of behavioral health, criminal justice, and other service providers who facilitate, provide, and share responsibilities of assessment coordination and treatment services to appropriately meet the complex mental, physical, and social needs of the targeted population. The target population includes individuals who may have severe and persistent mental illness, exhibit high-risk health and safety behaviors, engage in vagrancy-related criminal behavior, and experience severe SUDs; and for a variety of reasons, they are not accessing or accepting services.

TARGET POPULATION

- TAY 18-25
- Adults 26-59
- Older Adults 60 +

SERVICES AND ACTIVITIES

BHRS behavioral health services providers are embedded on the team to provide outreach and engagement services to the target population and support members with SMI by facilitating direct access to treatment services. The overarching goal is to see an increase in the target population transition from saying “no” to help to saying “yes” to help. Services provided include case management, outreach and engagement, behavioral health screening/assessment, psychoeducation, behavioral health services navigation and referrals, and transportation to help with access to services and/or community supports.

In FY 2023-2024, the estimated number of individuals to be served is 600.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$439,184	84	$5,228

PARTICIPANT DEMOGRAPHICS:

Unique Client Counts O&E - CARE		
Race	Individuals Served FY 23/24	
	Number	Percentage
African American	*	2%
Filipino	*	1%
Multiracial	*	1%
Other	*	1%
Unknown	67	80%
White	12	14%
Total:	84	100%

Due to privacy any value <10 has been removed

Unique Client Counts O&E - CARE		
Ethnicity	Individuals Served FY 23/24	
Hispanic Origin	Number	Percentage
Yes	*	8%
No	53	63%
Unknown	24	29%
Total	84	100%

Due to privacy any value <10 has been removed

Unique Client Counts O&E - CARE		
Ages	Individuals Served FY 23/24	
	Number	Percentage
Child (0-15)	0	0%
TAY (16-25)	*	8%
Adult (26-59)	64	76%
Older Adult (60+)	13	15%
Unknown	0	0%
Total	84	100%

Due to privacy any value <10 has been removed

Unique Client Counts O&E - CARE		
Language	Individuals Served FY 23/24	
	Number	Percentage
English	**81**	**96%**
Spanish	**0**	**0%**
Other	**0**	**0%**
Unknown	*****	**4%**
Total	**84**	**100%**

Due to privacy any value <10 has been removed

OUTCOMES:

MHSA Outcomes for O&E Community Assessment Response and Engagement (CARE)	
Outcomes	Number/Percentage FY 23/24
How Much?	
Individuals Served*	84
Average number of clinical services per individual*	0 0 / 84
Average number of support services per individual*	2 184 / 84
How Well?	
% of annual target of individuals served*	14% 84 / 600
Average length of OE Service -- days*	767 64,400 / 84
% of surveyed individuals were satisfied with services**	No Surveys Received
% of surveyed individuals said that "staff believed I could change"**	No Surveys Received
Better Off?	
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	No Surveys Received
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	No Surveys Received
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	No Surveys Received

Data Sources:
*SmartCare Data Warehouse for FY 2023-2024
**State Satisfaction survey results from May 2024 survey period May 20, 2024 - May 24, 2024.

GSD-01 Adult Residential Facilities

Operated By: Stanislaus County Behavioral Health and Recovery Services
System of Care: Office of the Public Guardian

PROGRAM DESCRIPTION

An Adult Residential Facility (ARF) is licensed by the state to provide enhanced behavioral health services with a higher staffing ratio than a regular board and care. This is an unlocked setting that provides care and supervision of members on conservatorship, and those who agree to stay at the facility and do not present a risk of leaving the facility. The ARF level of care can be used to avoid placement in an Institution for Mental Disease, and as a step down from the locked setting prior to progressing to the community.

The Department contracts with the following ARFs:

- Davis Guest Home
- Ever Well Health Systems
- Mar-Ric
- Turner Residential
- Carver Care Home
- Woods Board and Care Home
- Hope's Care Home
- A & A Health Services/Alamo Health Management
- GLOM

TARGET POPULATION

- BHRS Behavioral Health Service Teams (BHST) provide an adult with SMI or a co-occurring disorder access to a full range of services provided by multiple agencies, programs, and funding sources in a comprehensive and coordinated manner.
- The target populations identified for the BHST are adults, age 18 and older, who have been identified as having a Serious Mental Illness (SMI), with or without a co-occurring substance use disorder.
- These services can include psychosocial, rehabilitation, and recovery-oriented services. BHRS ultimately strives to provide behavioral health services to enhance the quality of life by empowering individuals to take charge of their own lives by promoting self-care and independence.
- BHSTs interact seamlessly with acute psychiatric inpatient facilities and, as well as with peer recovery services and housing programs. This includes but is not limited to, access to community residential care and/or treatment facilities, supported transitional and independent housing units, emergency and respite shelter and independent living skills services. The BHST also works in close collaboration with the County's Office of Public Guardian. The BHST works in collaboration with IMD providers and members to monitor treatment responses and identify members that are ready to be transitioned out of locked facilities and to facilitate stable re-entry into the community.

SERVICES AND ACTIVITIES

Transitional Board and Care programs will provide a broad range of services in an enriched, structured environment focused on each resident's specific needs and interest. Services shall be designed to enhance basic living skills, improve social functioning, allow for training opportunities within the community, and for participation in out-of-home activities, in an effort to normalize each resident's lifestyle. Such services are intended to help each resident reach and maintain his/her highest level of functioning resulting in a reintegration into the community. A schedule of these services will be developed each month outlining daily routines and opportunities. In addition, an Individual Program Plan (appraisal/needs & services plan) will be developed for each resident to target specific independent living skills and treatment goals. The Individual Program Plan will be focused on measurable goals and specific activities to be provided by the Transitional Board and Care. The BHSTs will work with the Transitional Board and Care to assist each resident in reaching the goals in the plan.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$11,192,382	287	$38,998

PARTICIPANT DEMOGRAPHICS:

Unique Client Counts: GSD - Adult Residential Facilities		
Race	Individuals Served FY 23/24	
	Number	Percentage
African American	*	2%
American Indian/ Alaskan Native	*	<1%
Asian	*	<1%
Laotian	*	1%
Multiracial	*	3%
Other	16	6%
Pacific Islander	*	<1%
Unknown	169	59%
White	81	28%
Total:	287	100%

Due to privacy any value <10 has been removed

Unique Client Counts: GSD - Adult Residential Facilities		
Ethnicity	Individuals Served FY 23/24	
Hispanic Origin	Number	Percentage
Yes	77	27%
No	158	55%
Unknown	52	18%
Total	287	100%

Due to privacy any value <10 has been removed

Unique Client Counts: GSD - Adult Residential Facilities		
Ages	Individuals Served FY 23/24	
	Number	Percentage
Child (0-15)	0	0%
TAY (16-25)	15	5%
Adult (26-59)	182	63%
Older Adult (60+)	63	22%
Unknown	27	9%
Total	287	100%

Due to privacy any value <10 has been removed

Unique Client Counts: GSD - Adult Residential Facilities		
Language	Individuals Served FY 23/24	
	Number	Percentage
English	**244**	**85%**
Spanish	**10**	**3%**
Other	*****	**1%**
Unknown	**29**	**10%**
Total	**287**	**100%**

Due to privacy any value <10 has been removed

Data Sources:
SmartCare Data Warehouse for FY 2023-2024

OUTCOMES:

Unique Client Counts: GSD - Adult Residential Facilities	
Outcomes	Number/Percentage FY 23/24
How Much?	
Individuals Served*	287
Average number of clinical services per individual*	52 14,885 / 287
Average number of support services per individual*	33 9,339 / 287
How Well?	
% of annual target of individuals served*	100% 287 / 287
Average Length of Service Days	670 192,418 / 287
% of surveyed individuals were satisfied with services**	No Surveys Received
% of surveyed individuals said that "staff believed I could change"**	No Surveys Received
Better Off?	
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	No Surveys Received
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	No Surveys Received
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	No Surveys Received

Data Sources:
*SmartCare Data Warehouse for FY 2023-2024
**State Satisfaction survey results from May 2024 survey period May 20, 2024 - May 24, 2024.

GSD-02 Residential Substance Use Disorder Board and Care

Operated By: Stanislaus Recovery Center, Nirvana, Redwood Treatment Center
System of Care: Substance Use Disorder (SUD)

PROGRAM DESCRIPTION

Residential services are provided for members when medically necessary within a short-term residential program. A client receiving Residential services pursuant to Drug Medi-Cal Organized Delivery System (DMC-ODS), regardless of the length of stay, is a "short-term resident" of the residential program in which they are receiving the services. These services are intended to be individualized to treat the functional deficits identified during a comprehensive assessment based on the American Society of Addiction Medicine (ASAM) criteria. Each client "lives" on the premises and is supported in their efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Residential treatment includes 24-hour structure with available trained personnel, seven days a week, including a minimum of five (5) hours of clinical service a week to prepare members to participate in outpatient treatment. SUD treatment services such as assessment, care coordination, individual and group counseling, family therapy, medication assisted treatment for opioid and alcohol use disorders and other non-opioid substance use disorders (or access to these services), patient education, medication services, recovery services, crisis intervention services, and discharge planning and coordination and transportation are provided. Treatment services are covered under the Drug Medi-Cal Organized Delivery System (DMC-ODS); however, the cost of room and board is not an allowable reimbursement. MHSA funds will be accessed for members with co-occurring behavioral health and substance use disorders since the availability of other funding for room and board is limited.

TARGET POPULATION

- SUD Treatment services are provided to persons meeting medical necessity for services, meaning services are reasonable and necessary to protect life, prevent significant illness/disability, or to alleviate severe pain. The need for residential treatment services is based upon a comprehensive assessment of ASAM criteria in six domains. Individuals who have a diagnosed substance use disorder (SUD) and significant impairment in multiple domains, whose treatment needs cannot be met in a less restrictive level of care, are placed in residential treatment services.
- MHSA funding for Board and Care expenses is targeted towards individuals with a SUD that are being concurrently treated by BHRS programs for a behavioral health condition.

SERVICES AND ACTIVITIES

Residential services encompass multiple levels of care, including Clinically Managed Withdrawal Management, Clinically Managed Low-Intensity, Clinically Managed Population Specific High Intensity, and Clinically Managed High Intensity services, and include multiple components:

- **Assessment**-evaluation/monitoring of behavioral health, determination of appropriate level of care and course of treatment (collection of information, diagnosis, intake/admission to programs, treatment planning)
- **Care Coordination**-activities to provide coordination of SUD care, behavioral health care, and medical care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level

- **Counseling** (individual and group)-Individual counseling consists of contact with the beneficiary, can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals. Group counseling consists of contacts with multiple beneficiaries at the same time. Group Counseling shall focus on the needs of the participants. Group counseling shall be provided to a group that includes 2-12 individuals.
- **Family Therapy**-provided by a Licensed Practitioner of the Healing Arts and include a beneficiary's family members and loved ones in the treatment process, providing education about factors that are important to the beneficiary's recovery as well as their own recovery. Family members may provide social support to beneficiaries, help motivate their loved one to remain in treatment and receive help and support for their own family recovery as well. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of this service, but the service is for the direct benefit of the beneficiary.
- **Medication Services**-provided by Physicians, PA/NP, Pharmacist, and RN, and include the prescription or administration of medication related to substance use treatment services, or the assessment of the side effects or results of that medication conducted by LPHA staff lawfully authorized
- **MAT for Opioid Use Disorders**-providers are required to either offer medications for addiction treatment (MAT, also known as medication-assisted treatment) directly, or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving outpatient (or residential) treatment services if not provided on-site
- **MAT for Alcohol Use Disorders and other non-opioid Substance Use Disorders**-providers are required to either offer medications for addiction treatment (MAT, also known as medication-assisted treatment) directly, or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving outpatient (or residential) treatment services if not provided on-site
- **Patient Education**-Includes providing research-based education on addiction, treatment, recovery and associated health risks
- **Recovery Services**-emphasize the beneficiary's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support
- **SUD Crisis Intervention Services**- "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis Intervention Services shall focus on alleviating the crisis problem, be limited to the stabilization of the beneficiary's immediate situation
- **Observation**-The process of monitoring the beneficiary's course of withdrawal. It is to be conducted as frequently as deemed appropriate for the beneficiary and the level of care the beneficiary is receiving. This may include, but is not limited to, observation of the beneficiary's health status (Withdrawal Management and MAT only)

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$82,046	**	**

PARTICIPANT DEMOGRAPHICS:

Unique Client Counts: SUD Residential		
Ethnicity	Individuals Served FY 22/23	
	Number	Percentage
African American	*	%
Asian	*	%
Hispanic	*	%
Native American	*	%
Other	*	%
Pacific Islander	*	%
Unknown	*	%
White	*	%
Total:	*	%

Due to privacy any value <10 has been removed

Unique Client Counts: SUD Residential		
Ages	Individuals Served FY 22/23	
	Number	Percentage
Child (0-15)	*	%
TAY (16-25)	*	%
Adult (26-59)	*	%
Older Adult (60+)	*	%
Total	*	%

Due to privacy any value <10 has been removed

Unique Client Counts: SUD Residential		
Ages	Individuals Served FY 22/23	
	Number	Percentage
Child (0-15)	*	%
TAY (16-25)	*	%
Adult (26-59)	*	%
Older Adult (60+)	*	%
Total	*	%

Due to privacy any value <10 has been removed

OUTCOMES:

MHSA Outcomes for SUD Residential	
Outcomes	Number/Percentage FY 22/23
How Much?	
Individuals Served*	*
Average number of clinical services per Individual*	*
Average number of support services per Individual*	*
How Well?	
% of annual target of individuals served*	*
Average length of O & E Service -- days*	*
% of surveyed individuals were satisfied with services**	*
% of surveyed individuals said that "staff believed I could change"**	*
Better Off?	
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	*
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	*
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	*

Due to privacy any value <10 has been removed

GSD-03 Housing Placement Assistance

Operated By: Stanislaus County Behavioral Health & Recovery Services
System of Care: SSD

PROGRAM DESCRIPTION
BHRS has partnerships with affordable housing developers/property managers to obtain and utilize properties to house BHRS members. These housing properties are spread across Stanislaus County and include:

- Transitional Housing (TH): TH refers to a supportive, yet temporary, type of accommodation that is meant to bridge the gap from homelessness to permanent housing by offering structure, behavioral health treatment support, housing supports such as life skills, and in some cases, education and training.

- Permanent Supportive Housing (PSH): PSH is an intervention that combines affordable housing assistance with voluntary support services to address the needs of chronically and at high-risk homeless people. The services are designed to build independent living and tenancy skills and connect people with community-based health care, treatment, and employment services.

TARGET POPULATION
- TAY Adults – age range is 18-25.
- Adults – age range 26-59
- Older Adults – age 60+

SERVICES AND ACTIVITIES
Provide on and off-site supports to individuals and their families residing in independent living housing situations. Support services are done one to one and in group settings and can include independent living skills such as budgeting, shopping, cooking, cleaning, socialization, etc., Housing retention is the main goal for housing supports.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$751,325	138	$2,408

PARTICIPANT DEMOGRAPHICS:

Unique Client Counts GSD Housing Placement Assistance		
Race	Individuals Served FY 23/24	
	Number	Percentage
African American	*	<1%
Asian/Pacific Islander	*	<1%
American Indian/ Alaska Native	*	1%
Filipino	*	<1%
Hmong	*	<1%
Multiracial	*	<1%
Other	*	<1%
Pacific Islander	*	<1%
Unknown	50	36%
White	62	45%
Total:	138	100%

Due to privacy any value <10 has been removed

Unique Client Counts GSD Housing Placement Assistance		
Ethnicity	Individuals Served FY 23/24	
Hispanic Origin	Number	Percentage
Yes	36	26%
No	96	70%
Unknown	6	4%
Total	138	100%

Due to privacy any value <10 has been removed

Unique Client Counts GSD Housing Placement Assistance		
Ages	Individuals Served FY 23/24	
	Number	Percentage
Child (0-15)	0	0%
TAY (16-25)	7	5%
Adult (26-59)	120	87%
Older Adult (60+)	11	8%
Unknown	0	0%
Total	138	100%

Due to privacy any value <10 has been removed

Unique Client Counts GSD Housing Placement Assistance		
Language	Individuals Served FY 23/24	
	Number	Percentage
English	**134**	**97%**
Spanish	*	**<1%**
Other	*	**<1%**
Unknown	*	**<1%**
Total	**138**	**100%**

Due to privacy any value <10 has been removed

Data Sources:
SmartCare Data Warehouse for FY 2023-2024

OUTCOMES:

MHSA Outcomes for GSD Housing Placement Assistance	
Outcomes	Number/Percentage FY 23/24
How Much?	
Individuals Served*	138
Average number of clinical services per individual*	0 14 / 138
Average number of support services per individual*	8 1,161 / 138
How Well?	
% of annual target of individuals served*	31% 138 / 452
Average length of O&E Service -- days*	276 38,056 / 138
% of surveyed individuals were satisfied with services**	No Surveys Received
% of surveyed individuals said that "staff believed I could change"**	No Surveys Received
Better Off?	
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	No Surveys Received
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	No Surveys Received
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	No Surveys Received

Data Sources:
*SmartCare Data Warehouse for FY 2023-2024
**State Satisfaction survey results from May 2024 survey period May 20, 2024 - May 24, 2024.

GSD-04 Employment Support Services

Operated By: Stanislaus County Behavioral Health & Recovery Services
System of Care: SSD

PROGRAM DESCRIPTION

Employment Support Services (ESS) provides supported employment for individuals with psychiatric disabilities, helping them achieve meaningful work and community integration. The program supports individuals with severe behavioral health conditions in obtaining and retaining competitive employment through services such as job coaching, vocational assessments, individualized employment plans, and skill-building workshops. ESS also fosters partnerships with employers and provides extensive support to help individuals re-enter the workforce and maintain long-term employment success.

The **Supportive Work Experience Program** is designed to help individuals entering or re-entering the workforce gain valuable skills and experience. This program offers individuals paid work opportunities, enabling them to build their resumes, enhance their job readiness, and become more competitive in the job market. By providing real-world experience in a supportive environment, the program aims to boost individuals' confidence, improve their employability, and prepare them for long-term career success.

TARGET POPULATION

- TAY Adults – age range is 18-25.
- Adults – age range 26-59

  Older Adults – age 60+

SERVICES AND ACTIVITIES

Pre-Employment skill building such as interview skills, resume writing, maintaining healthy relationships in the workplace, etc., Job Development: building relationships with companies/agencies for hiring purposes, Job Coaching: providing support either off or on-site to learn and maintain employment.

In FY 2023-2024, the estimated number of individuals to be served is 100.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$432,039	169	$2,556

PARTICIPANT DEMOGRAPHICS:

Unique Client Counts GSD - Employment Support Services		
Race	Individuals Served FY 23/24	
	Number	Percentage
African American	*	4%
American Indian/ Alaskan Native	*	2%
Asian	*	1%
Filipino	*	1%
Hmong	*	1%
Multiracial	*	5%
Other	20	12%
Unknown	77	46%
White	51	30%
Total:	169	100%

Due to privacy any value <10 has been removed

Unique Client Counts GSD - Employment Support Services		
Ethnicity	Individuals Served FY 23/24	
Hispanic Origin	Number	Percentage
Yes	59	35%
No	95	56%
Unknown	15	9%
Total	169	100%

Due to privacy any value <10 has been removed

Unique Client Counts GSD - Employment Support Services		
Ages	Individuals Served FY 23/24	
	Number	Percentage
Child (0-15)	0	0%
TAY (16-25)	17	10%
Adult (26-59)	149	88%
Older Adult (60+)	*	2%
Unknown	0	0%
Total	169	100%

Due to privacy any value <10 has been removed

Unique Client Counts GSD - Employment Support Services		
Language	Individuals Served FY 23/24	
	Number	Percentage
English	**157**	**93%**
Spanish	*	**4%**
Other	*	**1%**
Unknown	*	**2%**
Total	**169**	**100%**

Due to privacy any value <10 has been removed

OUTCOMES:

MHSA Outcomes for GSD - Employment Support Services	
Outcomes	Number/Percentage FY 23/24
How Much?	
Individuals Served*	169
Average number of clinical services per individual*	0 37 / 169
Average number of support services per individual*	2 353 / 169
How Well?	
% of annual target of individuals served*	169% 169 / 100
Average length of GSD Service -- days*	262 44,312 / 169
% of surveyed individuals were satisfied with services**	Less Than 10 Surveys Received
% of surveyed individuals said that "staff believed I could change"**	Less Than 10 Surveys Received
Better Off?	
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	Less Than 10 Surveys Received
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	Less Than 10 Surveys Received
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	Less Than 10 Surveys Received

Data Sources:
*SmartCare Data Warehouse for FY 2023-2024
**State Satisfaction survey results from May 2024 survey period May 20, 2024 - May 24, 2024.

GSD-05 Behavioral Health Wellness Center

Operated By: Stanislaus County Behavioral Health & Recovery Services
System of Care: SSD

PROGRAM DESCRIPTION

The Behavioral Health Wellness Center (BHWC) serves as a safe and welcoming community hub for BHRS members. The BHWC fosters peer support and strengthens recovery through a collaborative and inclusive environment. At the BHWC, Peer Support Specialist Staff and Peers work together to build strong peer and community networks. They engage in wellness, rehabilitative activities, and groups, and encourage mutual support in their recovery journeys. The BHWC offers members a relaxed, inclusive friendly space to connect, whether seeking support, someone to talk to, or simply spending time with peers. This supportive environment ensures that every client who walks through the door feels valued and included.

BHWC conducts community outreach at locations such as Modesto Gospel Mission, Turlock Gospel Mission, BHRS housing sites, and schools, as well as by participating in community events. Additionally, BHWC extends its outreach efforts to surrounding cities in the County, including Oakdale, Patterson and Turlock.

TARGET POPULATION

- TAY Adults – age range is 18-25.
- Adults – age range 26-59
- Older Adults – age 60+

SERVICES AND ACTIVITIES

The BH Wellness Center provides the community with groups and activities for individuals who have a serious mental illness. These groups and activities consist of; self-help groups such as self-esteem, life skills, men's-women's groups, co-occurring group, LGBTQ+ group, sewing group, music group, Spanish peer support group, movie group, etc. Staff also provide one-to-one peer supports on an individual basis.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$1,310,074	403	$3,251

SERVICES AND ACTIVITIES ACCESSED BY CONSUMERS FOR FY 2023-2024

The following data captures duplicative number of consumers that access The Behavioral Health Center's services and activities monthly for FY 2023-2024. Groups and activities in black are provided in-house. Field trips occur outside of the county. Groups and activities in red, orange, green, and purple are all provided in the community, including but not limited to BHRS Housing Sites, Shelters in various cities in Stanislaus County, and various community centers within Stanislaus County.

Program / FY	Behavioral Health Wellness Center 2023 - 2024												
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	TOTALS*
Onsite	485	593	447	562	419	491	608	520	644	623	770	659	6821
Café	322	413	284	396	351	359	392	381	419	412	491	355	4575
Advanced Sewing	78	62	48	78	48	33	32	28	49	66	42	50	614
Alano Club Socials	27	21	28	29	0	0	0	21	25	28	35	29	243
Anime Group				39	11	9	8	9	21	25	18	17	157
ART	34	41	38	35	23	30	40	31	22	28	29	13	364
Beginner's Music	13	20	18	18	7	14	19	9	18	15			151
Coed peer support	12	19	7	17	7	13	17	26	23	30	35	49	255
Community Socials	49	64	65	0	0	0	112	74	74	68	62	0	568
Co-occurring	52	63	75	59	23	59	52	64	52	21	65	38	623
Dungeons & Dragons												17	17
Field Trip	8	19	13					9	29	13	18	0	109
Flea Market Fridays	5	5	9	6	5	9	6	0	0	0	6	10	61
Gamers	33	48	18	24	27	35	48	49	47	48	71	52	500
Golfing								9	11	15	29	9	73
Intro to Meditation	13	13	4	10	14	7	7	6	7	14	8	14	117
LGBTQ+	3	3	0	5	0	7	7	6	7	14	8	14	74
Life Skills	60	67	50	70	54	49	77	52	47	45	50	34	655
Men's Group	33	39	35	31	22	17	41	28	52	36	38	24	396
Movie	29	42	27	40	11	32	28	21	23	14	59	17	343
Music (Advanced Music)	26	24	6	19	14	16	19	13	19	13	28	9	206
Outdoors activity	2	0	0	1	0	7	9	7	7	3	6	0	42
Photography											39	34	73
Seasonal Events				110	106	82							298
Self-esteem	11	31	14	24	27	34	37	18	30	37	39	36	338
Spanish peer support	4	4	0	0	0	0	0	0	0	0	0	1	9
Women's Group	35	25	33	37	27	12	18	11	18	32	17	24	289
Co-occurring (ZOOM)	5	5	6	1	5	6	4	4	1	3	2	5	47
Coed peer support (ZOOM)	5	8	5	1	1	0	5	1	0	3	3	18	50
Meditation (ZOOM)	2	1	1	1	0	0	0	3	1	0	1	2	12
Bennett Place	2	3	21	9	7	18	16	11	3	11	7	5	113
Courtney Manor	0	0	9	1	1	3	3	0	2	11	9	0	39
Garden Gate	5	4	5	9	11	9	13	9	12	9	1	4	91
Kansas House			0	25	0	2	5	0	1	3	6	3	45
Miller Point	4	1	0	0	5	2	7	14	14	11	15	6	79
Turlock Gospel Men's	21	12	10	13	33	16	22	32	49	40	20	28	296
Turlock Gospel Women's	29	25	26	25	25								130
Modesto Gospel Mission	OUTREACH ONLY												0
Patterson Naomi/HOST	8	27	27	24	18	16	15	18	6	12	12	5	188
Patterson Hammond	5	4	17	4	17	8	18	14	7	13	12	15	134

*BHWC Table represents the duplicated members served per month.

PARTICIPANT DEMOGRAPHICS:

Unique Client Counts GSD - Behavioral Health Wellness Center		
Race	Individuals Served FY 23/24	
	Number	Percentage
American Indian or Native American	**22**	**5%**
African American	**29**	**7%**
Assyrian	*	**1%**
Cambodian	*	**1%**
Filipino	*	**<1%**
Korean	*	**<1%**
Laotian	*	**<1%**
Native Hawaiian	*	**1%**
Other	**45**	**11%**
Other Pacific Islander	*	**1%**
Unknown	**131**	**33%**
Vietnamese	*	**<1%**
White or Caucasian	**156**	**39%**
Total:	**403**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts GSD - Behavioral Health Wellness Center		
Ethnicity	Individuals Served FY 23/24	
Hispanic Origin	Number	Percentage
Yes	**111**	**28%**
No	**173**	**43%**
Unknown	**119**	**30%**
Total	**403**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts GSD - Behavioral Health Wellness Center		
Ages	Individuals Served FY 23/24	
	Number	Percentage
Child (0-15)	**0**	**0%**
TAY (16-25)	**33**	**8%**
Adult (26-59)	**287**	**71%**
Older Adult (60+)	**72**	**18%**
Unknown	**11**	**3%**
Total	**403**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts GSD - Behavioral Health Wellness Center		
Language	Individuals Served FY 23/24	
	Number	Percentage
English	**259**	**64%**
Spanish	*****	**1%**
Other	*****	**1%**
Unknown	**135**	**33%**
Total	**403**	**100%**

Due to privacy any value <10 has been removed

Data Sources:
Wellness Center Program Provided information for FY 2023-2024

OUTCOMES:

MHSA Outcomes for GSD Behavioral Health Wellness Center	
Outcomes	Number/Percentage FY 23/24
How Much?	
Individuals Served*	403
How Well?	
% of annual target of individuals served*	161% (403 / 250)
% of surveyed individuals were satisfied with services**	100% (23 / 23)
% of surveyed individuals said that "staff believed I could change"**	100% (22 / 22)
Better Off?	
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	91% (20 / 22)
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	90% (19 / 21)
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	85% (111 / 130)

Data Sources:
*Wellness Center Program Provided information for FY 2023-2024
**State Satisfaction survey results from May 2024 survey period May 20, 2024 - May 24, 2024.

GSD-06 Behavioral Health Crisis and Support Line

Operated By: Stanislaus County Behavioral Health and Recovery Services
System of Care: Crisis and Assessment

PROGRAM DESCRIPTION

The Behavioral Health Crisis, and Support Line is a 24/7 call center for beneficiaries and community members of all ages, ethnic and religious backgrounds to access behavioral health services for either behavioral health or substance use (DMC-ODS) or both in Stanislaus County as well as crisis and support services. Calls are handled by behavioral health specialists (BHS) 24/7 who will provide linguistic support in the caller's preferred language in order to determine the caller's service needs. The BHS are trained to schedule or arrange for the scheduling of behavioral health assessments and DMC-ODS assessments. Crisis and support calls are also handled by BHS staff after determining the caller's service needs via brief telephone screenings, including linkage and referral to appropriate behavioral health services, as well as contacting 911 if applicable for emergency situations. Callers may be connected to trained behavioral health clinicians from the Community Emergency Response Team (CERT) to assist with de-escalating crisis situations, determining the level of crisis intervention needed and facilitating emergency psychiatric care. BHS staff are also available 24/7 for callers needing to speak to someone about non-emergent daily stressors, life challenges, behavioral health, and substance use issues.

TARGET POPULATION

- Children and Youth – age range 0 to 16
- TAY Adults – age range is 18-25.
- Adults – age range 26-59
- Older Adults – age 60+

SERVICES AND ACTIVITIES

- Receive all incoming referrals and calls from community members to schedule assessments
- Administer screening tools (both Adult and Youth) to determine the level of care
- Triage referrals to CERT for higher level of care
- Provide crisis intervention support and community referral information
- Compile date collection for State requirements

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$2,594,968	1747	$1,485

PARTICIPANT DEMOGRAPHICS:

Unique Client Counts GSD - Behavioral Health Crisis & Support Line		
Race	Individuals Served FY 23/24	
	Number	Percentage
African American	**88**	**5%**
American Indian/ Alaskan	**16**	**1%**
Asian	**14**	**1%**
Cambodian	*	**<1%**
Chinese	*	**<1%**
Filipino	*	**<1%**
Laotian	*	**<1%**
Multiracial	**91**	**5%**
Other	**310**	**18%**
Pacific Islander	*	**<1%**
Unknown	**716**	**41%**
White	**494**	**29%**
Total:	**1747**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts GSD - Behavioral Health Crisis & Support Line		
Ethnicity	Individuals Served FY 23/24	
Hispanic Origin	Number	Percentage
Yes	**545**	**31%**
No	**632**	**36%**
Unknown	**570**	**33%**
Total	**1747**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts GSD - Behavioral Health Crisis & Support Line		
Ages	Individuals Served FY 23/24	
	Number	Percentage
Child (0-15)	**216**	**12%**
TAY (16-25)	**307**	**18%**
Adult (26-59)	**1124**	**64%**
Older Adult (60+)	**100**	**6%**
Unknown	**0**	**0%**
Total	**1747**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts GSD - Behavioral Health Crisis & Support Line		
Language	Individuals Served FY 23/24	
	Number	Percentage
English	**1456**	**83%**
Spanish	**78**	**4%**
Other	**16**	**1%**
Unknown	**197**	**11%**
Total	**1747**	**100%**

Due to privacy any value <10 has been removed

Data Sources:
SmartCare Data Warehouse for FY 2023-2024

OUTCOMES:

MHSA Outcomes for GSD - Behavioral Health Crisis & Support Line	
Outcomes	Number/Percentage FY 23/24
How Much?	
Individuals Served*	1747
How Well?	
% of annual target of individuals served*	100% 1747 / 1747
% of surveyed individuals were satisfied with services**	No Surveys Received
% of surveyed individuals said that "staff believed I could change"**	No Surveys Received
Better Off?	
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	No Surveys Received
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	No Surveys Received
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	No Surveys Received

Data Sources:
*SmartCare Data Warehouse for FY 2023-2024
**State Satisfaction survey results from May 2024 survey period May 20, 2024 - May 24, 2024.

GSD-07 Short Term Residential Therapeutic Programs

Operated By: Aspiranet, Creative Alternatives and Sierra Vista Child & Family Services
System of Care: CSOC

PROGRAM DESCRIPTION

Short-Term Residential Therapeutic Program (STRTP) formerly known as group home, STRTP was established effective January 1, 2017, by Assembly Bill 403 (Chapter 773, Statutes of 2015). STRTP is a residential facility operated by a public agency or private organization and is licensed by California Department of Social Services (CDSS) pursuant to California Health and Safety Code Section 1562.01 which requires an integrated program of specialized and intensive care and supervision, services and supports, treatment, and 24-hour care and supervision to Wards and Dependent of the Court and/or Non Minor Dependents (NMDs) with the aim of moving the youth to a less restrictive environment within six months. The key to STRTPs is the provision of short-term, specialized and intensive behavioral health treatment to Wards and Dependents of the Court and NMDs whose needs cannot be safely met initially in a family setting. These core behavioral health services will be provided by STRTP staff through a Medi-Cal agreement with BHRS. Behavioral health services will include, at minimum, medication support services, case management, crisis intervention, and behavioral health services.

Stanislaus County has a total of three STRTPs:

- Sierra Vista STRTP: 2 Homes, 14 Beds Capacity (up to March 2024)
    - Woodbridge closed in March 2024
    - 8 Bed Capacity remains
- Aspiranet STRTP: 5 homes, 32 Beds Capacity
- Creative Alternatives STRTP:
    - 3 Homes, 24 Beds Capacity

TARGET POPULATION

- Children and Youth – age range 0 to 16
- TAY Adults – age range is 16-25

SERVICES AND ACTIVITIES

STRTPs provide covered Specialty Mental Health Services (SMHS) for Medi-Cal beneficiaries who meet criteria for placement in an STRTP. Services include the following behavioral health services: individual and group therapy, family counseling, targeted case management, individual and group rehabilitation, intensive care coordination (ICC), intensive home-based services (IHBS), crisis intervention and medication support.

In FY 2023-2024, the estimated number of individuals to be served is 60.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$632,038	73	$8,658

PARTICIPANT DEMOGRAPHICS:

Unique Client Counts GSD - Short Term Residential Therapeutic Programs (STRTP)		
Race	Individuals Served FY 23/24	
	Number	Percentage
African American	*	7%
Multiracial	*	5%
Other	*	1%
Pacific Islander	*	1%
Unknown	35	48%
White	27	37%
Total:	73	100%

Due to privacy any value <10 has been removed

Unique Client Counts GSD - Short Term Residential Therapeutic Programs (STRTP)		
Ethnicity	Individuals Served FY 23/24	
Hispanic Origin	Number	Percentage
Yes	21	29%
No	41	56%
Unknown	11	15%
Total	73	100%

Due to privacy any value <10 has been removed

Unique Client Counts GSD - Short Term Residential Therapeutic Programs (STRTP)		
Ages	Individuals Served FY 23/24	
	Number	Percentage
Child (0-15)	**58**	**79%**
TAY (16-25)	**15**	**21%**
Adult (26-59)	**0**	**0%**
Older Adult (60+)	**0**	**0%**
Unknown	**0**	**0%**
Total	**73**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts GSD - Short Term Residential Therapeutic Programs (STRTP)		
Language	Individuals Served FY 23/24	
	Number	Percentage
English	**70**	**96%**
Spanish	*	**1%**
Other	**0**	**0%**
Unknown	*	**3%**
Total	**73**	**100%**

Due to privacy any value <10 has been removed

Data Sources:

- SmartCare Data Warehouse for FY 2023-2024

OUTCOMES:

MHSA Outcomes for GSD - Short Term Residential Therapeutic Programs (STRTP)	
Outcomes	Number/Percentage FY 23/24
How Much?	
Individuals Served*	73
Average number of clinical services per individual*	167 12,162 / 73
Average number of support services per individual*	8 548 / 73
How Well?	
% of annual target of individuals served*	91% 73 / 80
Average length of GSD Service -- days*	744 54,329 / 73
% of surveyed individuals were satisfied with services**	60% 9 / 15
% of surveyed individuals said that "staff believed I could change"**	64% 9 / 14
Better Off?	
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	50% 7 / 14
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	71% 10 / 14
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	61% 22 / 36

Data Sources:
*SmartCare Data Warehouse for FY 2023-2024
**State Satisfaction survey results from May 2024 survey period May 20, 2024 - May 24, 2024

GSD-08 Crisis Residential Unit

Operated By: Central Star
System of Care: Crisis and Assessment

PROGRAM DESCRIPTION
The Crisis Residential Unit (CRU) is a voluntary short term 30-Day residential program. The CRU is a residential recovery-based treatment options, services and interventions. Members may apply after the first 30 days with a 90-day maximum stay.

TARGET POPULATION
- TAY Adults – age range from 18-25
- Adults – age range 26-59

SERVICES AND ACTIVITIES
Therapeutic and behavioral health services are provided including rehabilitation/recovery services for substance use. Services are available 24 hours a day including assessment, physical and psychological evaluation and services. Medication evaluation and support services (physician, nurse, and psychiatrist) are also available to assist the members with their MH and medical issues as needed. The CRU helps consumers practice real world recovery by participating in the day-to-day activities of running a household including basic living skills and social/interpersonal skills. Members are also assisted with locating permanent housing by helping members learn how to access community services for housing. In addition, Crisis Intervention is provided to help members de-escalate as well as providing referrals for 5150 Crisis Assessment as needed.

In FY 2023-2024, the estimated number of individuals to be served is 48.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$837,134	49	$17,084

PARTICIPANT DEMOGRAPHICS:

Unique Client Counts GSD - Crisis Residential Unit		
Race	Individuals Served FY 23/24	
	Number	Percentage
African American	*	12%
American Indian/ Alaskan Native	*	2%
Cambodian	*	2%
Other	*	10%
Unknown	16	33%
White	20	41%
Total:	49	100%

Due to privacy any value <10 has been removed

Unique Client Counts GSD - Crisis Residential Unit		
Ethnicity	Individuals Served FY 23/24	
Hispanic Origin	Number	Percentage
Yes	23	47%
No	24	49%
Unknown	*	4%
Total	49	100%

Due to privacy any value <10 has been removed

Unique Client Counts GSD - Crisis Residential Unit		
Ages	Individuals Served FY 23/24	
	Number	Percentage
Child (0-15)	0	0%
TAY (16-25)	10	20%
Adult (26-59)	38	78%
Older Adult (60+)	*	2%
Unknown	0	0%
Total	49	100%

Due to privacy any value <10 has been removed

Unique Client Counts GSD - Crisis Residential Unit		
Language	Individuals Served FY 23/24	
	Number	Percentage
English	**49**	**100%**
Spanish	**0**	**0%**
Other	**0**	**0%**
Unknown	**0**	**0%**
Total	**49**	**100%**

Due to privacy any value <10 has been removed

Data Sources:

- SmartCare Data Warehouse for FY 2023-2024

OUTCOMES:

% of annual target of individuals served*	272% 49 / 18
Average length of GSD Service -- days*	54 2,654 / 49
% of surveyed individuals were satisfied with services**	No Surveys Received
% of surveyed individuals said that "staff believed I could change"**	No Surveys Received
Better Off?	
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	No Surveys Received
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	No Surveys Received
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	No Surveys Received

Data Sources:
*SmartCare Data Warehouse for FY 2023-2024
**State Satisfaction survey results from May 2024 survey period May 20, 2024 - May 24, 2024.

GSD-09 Therapeutic Foster Care Services

Operated By: Not Operational in FY 2023-2024
System of Care: CSOC

PROGRAM DESCRIPTION
Therapeutic Foster Care (TFC) is a short-term, intensive, highly coordinated, trauma- informed, and individualized intervention, provided by a TFC parent to a child or youth who has complex emotional and behavioral needs.

TARGET POPULATION
- TFC is intended for children and youth who require intensive and frequent behavioral health support in a family environment.
- TFC is available to children and youth, under the age of 21, who are Medi-Cal eligible and meet medical necessity criteria.

SERVICES AND ACTIVITIES
TFC consists of one or more of the following: plan development, rehabilitation, and collateral and it is to be provided by a TFC Parent, who has received specialized training. TFC is an adjunct service that is provided alongside other Specialty Mental Health Services (SMHS) for the individual, as planned through the Child and Family Team (CFT). The TFC parent assists the child, youth, or young adult to achieve individualized goals and objectives that are part of a service plan, to improve functioning and well-being, and remain in a family-like home, in a community setting. TFC will be provided daily, up to 7 days a week, including weekends, at any time of day, as medically necessary.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
N/A	N/A	N/A

PARTICIPANT DEMOGRAPHICS:
N/A

OUTCOMES:
N/A

ADDITIONAL PROGRAM INFORMATION:

As of FY 2023-2024 Therapeutic Foster Care (TFC) program has not been implemented.

GSD-10 GSD Portion of Adult Medication Clinic

Operated By: Stanislaus County Behavioral Health and Recovery Services
System of Care: Medication Clinics

PROGRAM DESCRIPTION
Medication support for non-Full-Service Partnership BHSTs.
Adult Medication Clinics are located in Modesto and Turlock.

TARGET POPULATIONS

- TAY Adults – age range 18-25
- Adults – age range 26-59
- Older Adults – age 60+

SERVICES AND ACTIVITIES
The Adult Medication Clinic provides psychiatric consultation, evaluation, and treatment of members of BHRS and our community partners. Interventions include prescribing, administering, dispensing, and monitoring of psychotropic medications. The Clinic also provides consultation on non-medication related issues (e.g., medical-legal such as conservatorship) or other issues of concern to the treatment team. Clinic prescribers (psychiatrists and/or nurse practitioners) and nurses are part of the patient's interdisciplinary treatment team and help guide the course of a patient's treatment.

In FY 2023-2024, the estimated number of individuals to be served is 1,800.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$98,439	2428	$40.54

PARTICIPANT DEMOGRAPHICS:

Unique Client Counts GSD - Adult Medication Clinic		
Race	Individuals Served FY 23/24	
	Number	Percentage
African American	**89**	**4%**
American Indian/ Alaskan Native	**17**	**1%**
Asian	**15**	**1%**
Cambodian	*	**<1%**
Filipino	*	**<1%**
Guamanian	*	**<1%**
Hmong	*	**<1%**
Laotian	*	**<1%**
Multiracial	**109**	**4%**
Other	**253**	**10%**
Pacific Islander	*	**<1%**
Samoan	*	**<1%**
Unknown	**1271**	**52%**
White	**648**	**27%**
Total:	**2,428**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts GSD - Adult Medication Clinic		
Ethnicity	Individuals Served FY 23/24	
Hispanic Origin	Number	Percentage
Yes	**844**	**35%**
No	**1386**	**57%**
Unknown	**198**	**8%**
Total	**2428**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts GSD - Adult Medication Clinic		
Ages	Individuals Served FY 23/24	
	Number	Percentage
Child (0-15)	*	<1%
TAY (16-25)	437	18%
Adult (26-59)	1,738	72%
Older Adult (60+)	252	10%
Unknown	0	0%
Total	**2,428**	**100%**

Due to privacy any value <10 has been removed

Unique Client Counts GSD - Adult Medication Clinic		
Language	Individuals Served FY 23/24	
	Number	Percentage
English	2,258	93%
Spanish	105	4%
Other	20	1%
Unknown	45	2%
Total	**2,428**	**100%**

Due to privacy any value <10 has been removed

Data Sources:

- SmartCare Data Warehouse for FY 2023-2024

OUTCOMES:

MHSA Outcomes for GSD - Adult Medication Clinic	
Outcomes	Number/Percentage FY 23/24
How Much?	
Individuals Served*	2428
Average number of clinical services per individual*	6 14,624 / 2428
Average number of support services per individual*	0 718 / 2428
How Well?	
% of annual target of individuals served*	100% 2428 / 2428
Average length of GSD Service -- days*	610 1,480,558 / 2428
% of surveyed individuals were satisfied with services**	96% 26 / 27
% of surveyed individuals said that "staff believed I could change"**	96% 26 / 27
Better Off?	
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	73% 19 / 26
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	72% 18 / 25
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	87% 140 / 161

Data Sources:
*SmartCare Data Warehouse for FY 2023-2024
**State Satisfaction survey results from May 2024 survey period May 20, 2024 - May 24, 2024.

GSD-11 Central Valley Homes Development Project

Operated By: Stanislaus Regional Housing Authority
System of Care: SSD

PROGRAM DESCRIPTION

The Central Valley Homes Development Project is a 2-development scattered site project located at 413 Vine Street in Modesto and 1143 Park Street in Turlock with a total of 38 permanent supportive housing units. The development consists of 3 rehabilitation units at the Park Street location and 35 new construction units at the Vine Street location.

Each unit will have air conditioning, refrigerator, range, disposal, ceiling fans, curtains/blinds, and laundry hookups or appliances in units. On-site amenities include a picnic and BBQ area. Off-site amenities located within two miles of the project locations include:

- Public Transportation
- Shopping
- Medical Services
- Recreation
- Schools
- Employment Center

Of the total units, 19 will be dedicated to persons diagnosed with SMI.

TARGET POPULATION

- Adult, Older Adults, TAY individuals with a diagnosed serious mental illness.

SERVICES AND ACTIVITIES

The following supportive services will be available to tenants:

- Case Management such as comprehensive care and coordination of services, draft service plans, review/monitor program, linkage to physical health care and transportation assistance.
- Peer support activities such as support/specialty groups, one-to-one support, advocacy, socialization supports.
- Behavioral health care such as intake/assessment, crisis counseling, individual & group therapy, and medication services.
- Substance use services such as intake/assessment, treatment, individual & group therapy, relapse prevention, and peer support.
- Benefits counseling and advocacy such as assistance with accessing entitlement benefits such as SSI/SSP, Medi-Cal, and accessing retirement benefits.
- Basic housing retention skills such as money management, banking, affordable shopping, cooking, cleaning, laundry, conflict resolutions, and paying bills. Services for persons with co-occurring mental and physical disabilities or co-occurring mental and substance use disorders such as care coordination service, linkages to resources and providers, including routine and preventative care, and wellness services.
- Recreational and social activities such as social events such as neighborhood night out, local sporting

events, movie nights, crafting, art, how to relax, and faith based social networking.

- Education services such as assistance in accessing GED, school enrollment, higher educational benefits and grants, and accessing student services through schools.
- Employment services such as job readiness workshops, job development, on/off job coaching, job retention supports, paid job mentoring programs, and volunteer.
- Obtaining access to other needed services such as coordination and linkage to community resources such as food, clothing, including physical health, wellness services.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
N/A	N/A	N/A

PROJECT UPDATE:

Projects sites have been under development with an anticipated completion date of January 2025. Staff continue to identify housing applicants and assist with compiling documents needed for leasing.

Prevention and Early Intervention

PROGRAM DESCRIPTION

Prevention & Early Intervention (PEI) is the second-largest component of MHSA and represents 20% of MHSA funding. Per MHSA regulations, at least 51% of PEI funding must be dedicated to serving individuals 25 years or younger (California Code of Regulations, Title 9, § 3706 (b)). The programs are designed to prevent mental illness from becoming severe and disabling by recognizing the early signs and symptoms and improving access to services and programs. PEI's work is guided by MHSA values, the PEI regulations and the community planning process which includes stakeholder input. Each PEI program has a unique approach that incorporates community-based, promising practices or evidence-based strategies along with MHSA values of cultural competency, community collaboration, wellness, recovery/resiliency, client/family-driven services, and integrated service experience.

PEI programs provide a full spectrum of services for children/youth, adults and older adults who are either at-risk for or experiencing mental illness early in its emergence. These services collectively work to prevent mental illness from becoming severe and disabling through early recognition, and access and linkage to appropriate levels of services within the behavioral health system.
BHRS has continuously worked towards ensuring that required state policy and process changes, specifically affecting PEI, are aligned within PEI programs. As such, PEI has structured and redesigned programs to be focus on coordinated and consistent program results and outcomes to strengthen all MHSA PEI programs. These processes and structures are continuous and driven by required state policy and process changes as well as by community need.

Change in state law by Senate Bill 1004 (Chapter 843, Statutes of 2018) established priorities and a statewide strategy for prevention and early intervention services. The goal of this effort was to create a more focused approach to delivering effective prevention and early intervention services and increasing coordination and collaboration across communities and behavioral healthcare systems. The following priorities were established:

- Childhood trauma prevention and early intervention at the origins of behavioral health needs
- Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention across the lifespan
- Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnerships with college behavioral health programs
- Culturally competent and linguistically appropriate prevention and intervention services and strategies
- Strategies targeting the behavioral health needs of older adults

Outreach, engagement, and access and linkage activities are integrated into PEI programs to increase the effectiveness of the services. PEI regulations require that at least one program is dedicated to access and linkage. Aging and Veteran Services has been identified as the program with this focus and is described within this section. However, all PEI programs incorporate access and linkage activities and strategies.
In addition, all PEI programs are committed to providing services that embrace the MHSA general standards:

- Community Collaboration
- Cultural Competence
- Client Driven

- Family Driven
- Wellness, Recovery, and Resiliency Focused
- Integrated Service Experiences for members and their families

In Stanislaus County, the majority of PEI funded services are contracted out to our local community-based service providers, and many providers have more than one contracted PEI program to implement in communities across Stanislaus County.

The following illustrates how PEI programs are structured and categorized based on PEI regulations, in addition to what strategies and methods are required:

Prevention Programs are a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. Universal prevention may be used in prevention programs if there is evidence to suggest that universal prevention is an effective method for individuals and members of groups or populations whose risk of developing a serious mental illness is greater than average.

Early Intervention Programs 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. This may include the applicable negative outcomes that may result from untreated mental illness (suicide, incarcerations, school failure or dropout, unemployment, homelessness, and removal of children from their homes).

- Services shall not exceed 18 months (with exception of first onset of SMI/SED with psychotic features – 4 years)
- Early Intervention services may include services to parents, caregivers, and other family members of the person with early onset of a mental illness
- An Early Intervention program may be combined with a Prevention program
- All strategies listed in "required strategies" must be included

Outreach for Increasing Recognition of Early Signs of Mental Illness Program(s) 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 of potentially severe and disabling mental illness." Outreach may include reaching out to individuals with signs and symptoms of a mental illness, so they can recognize and respond to their own symptoms. It may also be a stand-alone program, a strategy within a prevention program, a strategy within an early intervention program, or a strategy within another program funded by PEI funds, or a combination thereof. Potential responders such as families, employers, primary health care providers, visiting nurses, school personnel, community service providers, peer providers, cultural brokers, law enforcement personnel**,** emergency medical service providers, people who provide services to individuals who are homeless, family law practitioners such as mediators, child protective services, leaders of faith-based organizations, and others in a position to identify early signs of potentially severe and disabling mental illness, provide support to, and/or refer individuals who need treatment or other behavioral health services.

Stigma and Discrimination Reduction Programs 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 behavioral health services and to increase acceptance,

dignity, inclusion, and equity for individuals with mental illness, and members of their families. This must include approaches that are culturally congruent with the values of the populations for whom changes in attitudes, knowledge, and behavior are intended. Some examples of stigma and discrimination reduction programs include, social marketing campaigns, speakers' bureaus and other direct-contact approaches, targeted education and training, anti-stigma advocacy, web-based campaigns, efforts to combat multiple stigmas that have been shown to discourage individuals from seeking behavioral health services and efforts to encourage self-acceptance for individuals with a mental illness.

Suicide Prevention Programs (optional per regulations) means organized activities that the County undertakes to prevent suicide as a consequence of mental illness. This category of programs does not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness. Suicide prevention activities that aim to reduce suicidality for specific individuals at risk of or with early onset of a potentially serious mental illness can be a focus of a Prevention or an Early Intervention program. Examples of suicide prevention programs include, public and targeted information campaigns, suicide prevention networks, capacity building programs, culturally specific approaches, survivor-informed models, screening programs, suicide prevention hotlines, web-based suicide prevention resources, and training and education.

Access and Linkage to Treatment means connecting children with severe mental illness, and 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 behavioral health programs. Examples of access and linkage to treatment programs include, programs with a focus on screening, assessment, and referrals, telephone help lines, or with a focus on mobile response.

Required Strategies and Methods for PEI Programs:
Required Strategies in prevention, early intervention, outreach for increasing recognition of early signs of mental illness, stigma and discrimination reduction, access and linkage to treatment, and suicide prevention (optional) programs include designing and implementing programs to help create access and linkage to treatment. Programs must also be promoted in ways that improve timely access to behavioral health services for individuals and/or families from underserved/unserved populations. Additionally, programs must be implemented and promoted using strategies that are non-stigmatizing and nondiscriminatory. Services shall be provided in convenient, accessible, acceptable, culturally appropriate settings (public settings) unless a behavioral health setting enhances access to quality services and outcomes for underserved/unserved populations.

Required methods must be likely to bring about intended outcomes, based on one or more of the following standards: evidence-based practice, promising practice, and community and/or practice-based evidence.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$4,733,682	4,508	$1,050

Prevention

PREVENTION PROGRAM DESCRIPTION

Prevention programs provide services to children/youth, adults and older adults who are either at-risk for or experiencing mental illness early in its emergence or who are at-risk for developing a serious mental illness. Prevention programs provide a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. The goal of prevention programs is to provide behavioral health resources, support, and services.

Prevention programs focus on the following:

- Implement services that promote wellness, foster health, and prevent the suffering that can result from untreated mental illness
- Pursue policy and community change that supports positive cognitive, social and emotional development and encourages a state of well-being
- Champion efforts to train individuals to be able to recognize and support fellow community members impacted by behavioral health
- Foster communities free of stigma in which persons affected by mental illness are able and willing to seek services

Prevention outcomes include reducing the applicable adverse effects as a result of untreated mental illness for individuals and members of groups or populations whose risk of developing a serious mental illness is significantly greater than average and, as applicable, their parents, caregivers, and other family members.

TARGET POPULATION

- Children and Youth – age range 0 to 15
- TAY Adults – age range 16-25
- Adults – age range 26-59
- Older Adults – age 60+
- Individuals at-risk for serious mental illness or exhibiting onset of serious mental illness or displaying mental illness early in its emergence and/or;
- Families of individuals in the underserved/unserved, at-risk population;
- Additional target populations include: Latino/Hispanic, Asian Pacific Islander, African American, Assyrian, Middle Eastern, the refugee community, and Lesbian, Gay, Bi-Sexual, Transgender, and Questioning (LGBTQ) individuals.

SERVICES AND ACTIVITIES

Prevention programs provide services that reduce risk factors and increase protective factors. These services include one-to-one support, screenings, referrals and behavioral health navigation assistance, presentations, training, and other engagement and outreach activities. Similar to early intervention programs, all prevention programs are designed and implemented to help create access and linkage to treatment and improve timely access to behavioral health services for individuals and families from underserved/unserved populations when appropriate. Services are provided in convenient, accessible, and culturally appropriate settings using strategies that are non-stigmatizing and non-discriminatory.

PREVENTION PROGRAMS FY 2023-24

- Promotores/Community Behavioral Health Outreach Workers Operated By:
  - AspiraNet – serving Turlock
  - Center for Human Services – serving Modesto Airport Neighborhood, Ceres, Keyes, Newman, Crows Landing, Riverdale Park Tract, Monterey Park Tract, Patterson, and Grayson/Westley
  - Sierra Vista – serving South Modesto, Denair, Hickman, Waterford, Empire, Hughson, Salida, and North Modesto
  - Oak Valley Hospital - Family Support Network – serving Oakdale and Riverbank
  - Parent Resource Center – serving West Modesto
- Child and Youth Resiliency Prevention Operated By:
  - El Concilio - Youth Behavioral Health Outreach Worker (YBHOW)
  - Sierra Vista - Youth Assessment Center (YAC)

PREVENTION PROGRAMS DESCRIPTIONS:

Promotores/Community Behavioral Health Outreach Workers (CBHOW) Program

The Promotores/CBHOW focus on various strategies to work particularly closely with the Latino communities throughout Stanislaus County. The program also has a strong focus on promoting prevention-focused and community-based behavioral health education and activities, particularly in communities historically underserved/unserved for individuals and families of individuals at risk of exhibiting onset of serious mental illness or displaying mental illness early in its emergence. The Promotores/CHBOW promote behavioral health and well-being, build protective factors to reduce the risk of developing a potentially serious behavioral health condition, and link those experiencing early onset of serious mental illness to appropriate services. A Promotor/CBHOW represents a rich spectrum of characteristics that facilitate natural communities of support as leaders in their communities and non-clinical providers. Promotores/CBHOW are the bridge between behavioral health care institutions, professional providers, and community residents.

*******Please note that due to financial hardship, the contractor Oak Valley Hospital ended their contract early (March 29, 2024, was their last day of business) consequently, causing the loss of these impactful services to the Riverbank & Oakdale communities.

Child and Youth Resiliency Programs

The Youth Assessment Center (YAC) program serves youth ranging from ages 12-25 from culturally and geographically underserved/unserved and at-risk populations throughout Stanislaus County. The program targets youth who are at risk of school failure, substance abuse, mental illness, social inequality, exposed to violence and/or involvement with the juvenile justice system. The program creates opportunities that promote bonding, foster resilience, strengthen social and emotional competence and develops relationships/partnerships with the larger community.

The Youth Behavioral Health Outreach (YBHOW) program focuses on enhancing emotional health, behavioral health & wellbeing, promotes prevention-focused and community-based behavioral health education and activities, particularly in communities and populations historically underserved/unserved. The program serves youth and young adults ranging from ages 12-25 years of age who are at risk of school failure, substance abuse, mental illness, social inequality, exposure to violence and/or involvement with the juvenile justice system. The initiative creates opportunities for profound relational practice and learning experiences that promote

bonding, foster resilience, strengthens social and emotional competence, familial involvement, and development of relationships/partnerships with the larger community.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$1,289,233	1,707	$755

PREVENTION PROGRAM PARTICIPANT DEMOGRAPHICS:

Ages	Individuals Served FY 23/24	
	Number	Percentage
Child/Youth (0-15)	559	33%
TAYA (16-25)	168	10%
Adult (26-59)	671	39%
Older Adult (60+)	130	8%
Unknown	179	10%
Total:	**1,707**	**100%**

Language	Individuals Served FY 23/24	
	Number	Percentage
English	323	19%
Spanish	1364	80%
Other	8	<1%
Unknown	12	<1%
Total:	**1,707**	**100%**

Gender	Individuals Served FY 23/24	
	Number	Percentage
Male	326	19
Female	1288	76
Genderqueer	0	0
Questioning/Unsure	*	<1%
Transgender	0	0
Another	0	0
Unknown	88	5%
Total:	**1,707**	**100%**

Race	Individuals Served FY 23/24	
	Number	Percentage
American Indian / Alaska Native	*	<1%
Asian	*	<1%
Black/African American	18	1%
Native Hawaiian / Pacific Islander	*	<1%
White	1279	75%
More than one race	241	14%
Other	21	1%
Unknown	135	8%
Total:	**1,707**	**100%**

Ethnicity	Individuals Served FY 23/24	
	Number	Percentage
Hispanic or Latino	1,554	91%
Non-Hispanic or Latino	116	7%
Declined/Unknown	37	2%
Total:	**1,707**	**100%**

Due to privacy any value <10 has been removed
*Data source: PEI Database

OUTCOMES:

Outcomes	Number FY 23/24
How Much?	
# Promotores Program Participants	1,451
# Services Provided	21,531
# Services Dedicated to Promotores Development	380
# Services Focused on Leadership	282
# One-on-one Support Sessions	1,848
# Information & Referral Services	3,328
How Well?	
# Presentations Covering the Topic of Accessing Behavioral Health Services	252
Better Off?	
As a result of participating in these programs, individuals have reported: • Having created meaningful relationships • Improvement in their wellbeing • Knowing how to access behavioral health services	

*Data Source: PEI Database

Early Intervention

EARLY INTERVENTION PROGRAM DESCRIPTION
Early Intervention (EI) programs provide treatment and other services and interventions to address and promote recovery and related functional outcomes for a mental illness early in its emergence. The services can include relapse prevention and outcomes encompass the decrease of applicable negative outcomes that may result from untreated mental illness such as suicide, incarcerations, school failure or dropout, unemployment, homelessness, and removal of children from their homes.

Treatment services are designed for adolescents that are accessing behavioral health services for the first time or have had an undertreated severe emotional disturbance episode. The program provides intensive treatment services for up to 18 months, with the aim of supporting program participants move to a lower level of care and access community supports. For members that need treatment services beyond the 18 months, they are referred to and continue services through an appropriate level of care. Early Intervention Programs include the following:

TARGET POPULATION

- Children and Youth – age range 0 to 15
- TAY Adults – age range 16-25
- Adults – age range 26-59
- Older Adults – age 60+
- Individuals at-risk for serious mental illness or exhibiting onset of serious mental illness or displaying mental illness early in its emergence and/or.
- Families of individuals in the underserved/unserved, at-risk population.
- Additional target populations include Latino/Hispanic, Asian Pacific Islander, African American, Assyrian, Middle Eastern, the refugee community, and Lesbian, Gay, Bi-Sexual, Transgender, and Questioning (LGBTQ) individuals

SERVICES AND ACTIVITIES
Early Intervention (EI) The Early Intervention program provides assessment, treatment and supportive services to children and youth ages 0 through 17 years of age, with a focus on children or youth new to the behavioral health system with a first-time diagnosis. Referrals may come from a variety of sources, including other programs, schools, parents/caregivers, and other community partners. The services are intended to be short-term, up to 18 months, and include behavioral health treatment and other interventions that address and promote recovery.

EARLY INTERVENTION PROGRAMS FY 2023-2024

- Early Psychosis Intervention –
    - LIFE Path, Early Psychosis Operated by Sierra Vista Child and Family Services
- School Behavioral Health Integration
    - School-Based Consultation Services operated by Stanislaus County Behavioral Health and Recovery Services

EARLY INTERVENTION PROGRAMS DESCRIPTIONS:

LIFE Path, Early Psychosis
The LIFE Path EPI program serves youth ages 14 to 25 experiencing early symptoms of psychosis. The program focuses on empowering and creating hope for culturally diverse youth and young adults to continue on their path through effective treatment, support and connection.

School-Based Consultation Services
This program provides behavioral health services by SCBHRS Behavioral Health clinicians. The clinicians provide guidance & support to a growing collaboration of designated community leaders and agencies from prevention services funded programs, BHRS funded programs, schools, and other community-based behavioral health & wellness programs. Doing so ensures access to this prevention strategy in outlying areas where transportation and other factors are barriers to services in traditionally centralized locations.

School-Based Consultation Clinician tasks may consist of (depending on the needs of the individual):

1. BH (**B**ehavioral **H**ealth) Screenings/assessments
2. Individual support sessions & Brief Intervention, Group Support Sessions
3. BH Consultation; working to help the community to build capacity in independent self-defined views of wellbeing, wellness & overall behavioral health by designing and conducting BH related presentations, workshops, trainings & technical assistance to audiences such as school staff, teachers, administrators, parents, caregivers, other family members and/or surrounding community members who fall into the unserved/underserved populations
4. Education with a focus around Access & Navigation Services to Behavioral Health services
5. BH prevention focused Community Outreach and Engagement (COE) efforts (Stigma reduction presentations, education and awareness around Suicide, SEL (**S**ocial **E**motional **L**earning) and statewide campaign efforts, etc.)

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$2,258,492	156	$14,478

EARLY INTERVENTION PROGRAM PARTICIPANT DEMOGRAPHICS:

Ages	Individuals Served FY 23/24	
	Number	Percentage
Child/Youth (0-15)	21	14%
TAYA (16-25)	55	35%
Adult (26-59)	13	8%
Older Adult (60+)	*	1%
Unknown	66	42%
Total:	**156**	**100%**

Language	Individuals Served FY 23/24	
	Number	Percentage
English	120	77%
Spanish	31	20%
Other	0	0
Unknown	*	3%
Total:	**156**	**100%**

Gender	Individuals Served FY 23/24	
	Number	Percentage
Male	59	38%
Female	88	56%
Genderqueer	0	0%
Questioning/Unsure	0	0%
Transgender	0	0%
Another	0	0%
Unknown	*	6%
Total:	**156**	**100%**

Race	Individuals Served FY 23/24	
	Number	Percentage
American Indian / Alaska Native	0	0%
Asian	*	2%
Black/African American	*	2%
Native Hawaiian / Pacific Islander	0	0%
White	125	80%
More than one race	*	2%
Other	*	1%
Unknown	*	13%
Total:	**156**	**100%**

Ethnicity	Individuals Served FY 23/24	
	Number	Percentage
Hispanic or Latino	86	55%
Non-Hispanic or Latino	*	6%
Declined/Unknown	60	39%
Total:	**156**	**100%**

Due to privacy any value <10 has been removed
*Data source: PEI Database

OUTCOMES:

Outcomes	Number FY 23/24
How Much?	
# Unique Individuals Served	156
# Services Provided	1,299
# Brief Intervention Counseling Services Provided	544
How Well?	
# Services Provided outside the office	745
Better Off?	
% Individuals that Indicated a Decrease in Depression Severity using PHQ-9 After Receiving Brief Intervention Counseling	62%

*Data Source: PEI Database

Outreach for Increasing Recognition of Early Signs of Mental Illness
Stigma and Discrimination Reduction
Suicide Prevention

The PEI programs in the categories below overlap and are embedded and addressed by multiple programs across the PEI system of care. However, there are specific programs dedicated to each of these categories.

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS PROGRAM DESCRIPTION

Programs and strategies focused on outreach for increasing recognition of early signs of mental illness utilize outreach, which 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 of potentially severe and disabling mental illness.

STIGMA AND DISCRIMINATION REDUCTION PROGRAM DESCRIPTION

Stigma and discrimination reduction programs encompass the 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 behavioral health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.

SUICIDE PREVENTION PROGRAM DESCRIPTION

Suicide prevention programs are those that organize activities to prevent suicide as a result of mental illness. This category of programs does not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness.

TARGET POPULATION

- Children and Youth – age range 0 to 15
- TAY Adults – age range is 16-25.
- Adults – age range 26-59
- Older Adults – age 60+
- Individuals at-risk for serious mental illness or exhibiting onset of serious mental illness or displaying mental illness early in its emergence and/or;
- Families of individuals in the underserved/unserved, at-risk population;
- Additional target populations include: Latino/Hispanic, Asian Pacific Islander, African American, Assyrian, Middle Eastern, the refugee community, and Lesbian, Gay, Bi-Sexual, Transgender, and Questioning (LGBTQ) individuals

SERVICES AND ACTIVITIES

PEI alongside Community Cultural Collaboratives that are comprised of diverse community partners implement PEI strategies within the category of Outreach for Increasing Recognition of Early Signs of Mental Illness. These activities are designed to encourage, educate, and train individuals and potential responders about ways to recognize and respond effectively to early signs of mental illness. The strategies utilized have a focus on behavioral health awareness, stigma reduction, and access and linkage to appropriate behavioral health services. Outreach services are provided throughout all PEI programs at varying degrees.

Stigma and discrimination reduction activities also include presentations, training, and events, marketing campaigns, speakers' bureaus, and efforts to encourage self-acceptance for individuals with a mental illness. All PEI programs integrate one or more of these activities in their program delivery at varying degrees.

Additionally, in the area of suicide prevention, a service offered through PEI is the suicide hotline contribution provided by the Central Valley Suicide Prevention Hotline (CVSPH). CVSPH is nationally accredited by the American Association of Suicidology and operates the hotline 24 hours a day, 7 days a week, ensuring that our county residents have access to suicide prevention support and emergency services when appropriate. CalMHSA provides support in the areas of suicide prevention and stigma and discrimination reduction and is the fiscal agent for CVSPH. Other suicide prevention activities include campaigns, training, and education focused on suicide information and prevention.

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS FY 2023-2024 Programs

- Outreach Programs for Increasing Recognition of Early Signs of Mental Illness:
    - Community Based Cultural and Ethnic Engagement (Community Cultural Collaboratives)
    - Community Trainings are operated by Stanislaus County Behavioral Health and Recovery Services
    - Behavioral health education and trainings operated by NAMI (National Alliance on Mental Illness)
    - Friends are Good Medicine

STIGMA AND DISCRIMINATION REDUCTION FY 2023-2024 PROGRAMS

- Stigma and Discrimination Reduction Programs Operated By:
    - Take Action for Behavioral Health/Know the Signs
    - CalMHSA

SUICIDE PREVENTION FY 2023-2024 PROGRAMS

- Suicide Prevention Programs Operated By:
    - Kingsview – Central Valley Suicide Prevention Hotline (individuals with suicidal ideation or at-risk).

PROGRAM DESCIPTIONS:

Community Based Cultural and Ethnic Engagement (Community Cultural Collaboratives)

Community Cultural Collaborative partners are cultural community-based groups who, in conjunction with Stanislaus County BHRS efforts, empower the community and individuals who struggle with mental illness and/or substance use disorders. Community Cultural Collaboratives are comprised of members form different cultural backgrounds and are part of PEI strategies for Outreach for Increasing Recognition of Early Signs of Mental Illness and Access & Linkage to appropriate behavioral health services that target MHSA priority populations.

Community Trainings
Community trainings are comprised of PEI staff, other Stanislaus County BHRS staff, contracted partners and community collaboratives. They serve as trainers for the following trainings that are provided free of cost to the community to targeted PEI populations across the county:

- Mental Health First Aid (MHFA)
- Youth Mental Health First Aid
- Applied Suicide Intervention Skills Trainings (ASIST)
- NAMI Provider Education Course

Friends are Good Medicine
A county-wide directory to publicize support groups and encourage emotional health. The directory's focus is to provide updated peer support information and promote the concept of self-help in both the general and professional community. Friends are Good Medicine provides a wide range of support groups including, Spanish-speaking well-being groups and mental and emotional health groups. Resources are continuously changing, given it is a peer-led network. The directory is offered as an online resource. It is printed and distributed throughout Stanislaus County. Stanislaus County BHRS supports the printing in both English and Spanish as the reproduction of this valuable guide.

National Alliance on Mental Illness (NAMI)
NAMI provides behavioral health education and trainings throughout the County primarily in the school classroom setting to reduce stigma related to mental illness. NAMI has five primary areas of focus including outreach, engagement, access and linkage, improve timely access to behavioral health services, and promoting, designing, and implementing programs related to mental illness. NAMI provides presentations to diverse communities, potential responders, and individuals at-risk by utilizing individuals with lived experience to present and better connect with community. The ultimate goal of providing education and training, is to strengthen individual and community wide behavioral health protective factors and provide access to behavioral health services.

Take Action for Mental Health and Know the Signs
*(Each Mind Matters Campaign is a statewide campaign which has transitioned to become, Take Action for Mental Health.) Take Action for Mental Health and Know the Signs are statewide social marketing campaigns built on three key messages: Know the signs. Find the words. Reach out. This campaign is intended to educate Californians on how to recognize the warning signs of suicide, how to find the words to have a direct conversation with someone in crisis and where to find professional help and resources. Take Action for Mental Health is a behavioral health awareness campaign focused on creating a platform for individuals to check-in, learn more & to get support for behavioral health in an effort to reduce stigma and discrimination related to behavioral health. These campaigns are funded through counties by the voter approved Mental Health Services Act (MHSA) (Prop. 63) and administered by the California Mental Health Services Authority (CalMHSA), an organization of county governments working to improve behavioral health outcomes for individuals, families and communities.

CalMHSA
The CalMHSA (California Mental Health Services Authority) program disseminates and directs statewide PEI project campaigns, programs, resources, and materials; provides subject matter in suicide prevention and stigma and discrimination reduction (SDR) to support local PEI efforts; develops local and statewide capacity building support and new outreach materials for counties, and community stakeholders. The primary focus of

these programs is to promote behavioral health and wellness, suicide prevention, and health equity to reduce the likelihood of mental illness, substance use, and suicide among Californians, particularly among diverse and underserved/unserved communities. In addition, the program also supports a portion of the Central Valley Suicide Prevention hotline, an immediate and consistent support for individuals in crisis or experiencing a suicidal crisis. The hotline is available 24 hours a day, 365 days a year, and is confidential and free.

Central Valley Suicide Prevention Hotline (CVSHP)

CVSHP provides 24/7 hotline assistance to individuals who are looking for resources and education regarding a loved one or a friend, provides support for those in crisis and keeps people safe who have suicidal ideation or that are in the process of harming themselves. CVSPH serves California's Central Valley which is a culturally diverse group of seven counties. The hotline is also a member of the National Suicide Prevention Lifeline which provides interpreters for 150 different languages.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$792,836	2,290	$346

OUTREACH PROGRAMS FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS, STIGMA AND DISCRIMINATION REDUCTION, AND SUICIDE PREVENTION PROGRAM PARTICIPANT DEMOGRAPHICS:

Ages	Individuals Served FY 23/24	
	Number	Percentage
Child/Youth (0-15)	65	3%
TAYA (16-25)	244	11%
Adult (26-59)	426	18%
Older Adult (60+)	69	3%
Unknown	1,486	65%
Total:	**2,290**	**100%**

Language	Individuals Served FY 23/24	
	Number	Percentage
English	1,740	76%
Spanish	*	<1%
Other	18	<1%
Unknown	529	23%
Total:	**2,290**	**100%**

Gender	Individuals Served FY 23/24	
	Number	Percentage
Male	472	21%
Female	527	23%
Genderqueer	*	<1%
Questioning/Unsure	*	<1%
Transgender	*	<1%
Another	*	<1%
Unknown	1,266	55%
Total:	**2,290**	**100%**

Race	Individuals Served FY 23/24	
	Number	Percentage
American Indian / Alaska Native	*	<1%
Asian	11	<1%
Black/African American	18	1%
Native Hawaiian / Pacific Islander	0	0%
White	152	7%
More than one race	16	1%
Other	100	4%
Unknown	1,989	87%
Total:	**2,290**	**100%**

Ethnicity	Individuals Served FY 23/24	
	Number	Percentage
Hispanic or Latino	122	5%
Non-Hispanic or Latino	163	7%
Declined/Unknown	2005	88%
Total:	**2,290**	**100%**

Due to privacy any value <10 has been removed

*Data source: PEI Database

OUTCOMES:

Outcomes	Number FY 23/24
How Much?	
# Calls Responded to Through the Central Valley Suicide Prevention Hot Line	2,249
# Crisis Calls to Central Valley Suicide Prevention Hotline	950
How Well?	
# Calls Concerned with Behavioral Health	1,126
# "Active Rescues" When Emergency Services were Contacted for the Caller's Safety	16
Better Off?	
# Talk Downs During which a High-Risk Caller was Deterred from Completing Suicide	12
Estimated Cost Savings to Stanislaus County for Crisis Calls	$2,584,217

*Data Source: Suicide Hotline Data

Access and Linkage Program

ACCESS AND LINKAGE PROGRAM DESCRIPTION

Access and Linkage to treatment means connecting individuals with severe mental illness, 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 behavioral health programs. Examples include focusing on screening, assessment, referral, and/or mobile response. This Access and Linkage program provides confidential peer-staffed outreach, education, referral, and support services to the veteran and aging community, their families, and the service providers. The program increases awareness of the prevalence of mental illness in Stanislaus County, reduces behavioral health risk factors or stressors, and improves access to behavioral health and PEI services, information, and support.

TARGET POPULATION:

The Aging and Veteran Services program primarily serves the geographic community of Modesto and the underserved/unserved populations within it. The program serves mostly adults and adults older than 60 years of age, including all races and ethnicities, and veterans and their family members. The primary target population includes older adults with mild depression, at risk of depression or worsening depression.
All programs target Stanislaus County's underserved/unserved populations in the following categories:

- Individuals at-risk or exhibiting onset of serious mental illness
- Individuals displaying mental illness early in its emergence
- Families of individuals in the above populations

This Access and Linkage program specifically targets adults and older adults who are also at high risk for having or developing mental illness due to risk factors:

- Isolation – social, geographic, cultural, linguistic
- Losses - deaths, financial, independence
- Multiple chronic medical conditions including substance abuse
- Elder abuse and neglect

SERVICES AND ACTIVITIES:

Aging and Veteran Services (AVS) provides specific home and community-based services. Efforts are made via a network of older adult service providers, including home health agencies, adult protective services, and community service organizations (home-delivered meals, in-home service providers, and transportation programs.

This program primarily serves adults and older adults with an emphasis on MHSA underserved and unserved populations. The program provides individual and group engagement activities and services, identifies at-risk individuals and potential responders, and provides referrals, navigation, and other support through the Friendly Visitor program. All PEI programs are designed and implemented to help create access and linkage to treatment and improve timely access to behavioral health services for individuals and families from underserved/unserved populations when appropriate, but this program has a strong focus in this area.
PEI regulations require that at least one program is dedicated to access and linkage, and Aging and Veteran Services has been identified as the program with this focus. However, all PEI programs incorporate access and linkage activities and strategies, and Aging and Veteran Services is also a program providing Brief Intervention Counseling (BIC) services.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$393,120	355	$1,107

FY 2023-2024:

MHSA regulations require that one program be appointed as the designated Access and Linkage program. Aging and Veteran Services is the program that has been appointed under this category. It is important to note that all PEI programs are designed and implemented to help create access and linkage to treatment and improve timely access to behavioral health services for individuals and families from underserved/unserved populations when appropriate. Services are provided in convenient, accessible, and culturally appropriate settings using strategies that are non-stigmatizing and non-discriminatory. Access and linkage activities are also integrated into all programs to increase the effectiveness of the services.

ACCESS AND LINKAGE PROGRAM PARTICIPANT DEMOGRAPHICS:

Ages	Individuals Served FY 23/24	
	Number	Percentage
Child/Youth (0-15)	*	2%
TAYA (16-25)	*	<1%
Adult (26-59)	11	3%
Older Adult (60+)	330	93%
Unknown	*	1%
Total:	**355**	**100%**

Language	Individuals Served FY 23/24	
	Number	Percentage
English	271	76%
Spanish	22	6%
Other	*	<1%
Unknown	61	17%
Total:	**355**	**100%**

Gender	Individuals Served FY 23/24	
	Number	Percentage
Male	60	17%
Female	204	57%
Genderqueer	0	0%
Questioning/Unsure	0	0%
Transgender	0	0%
Another	0	0%
Unknown	91	26%
Total:	**355**	**100%**

Race	Individuals Served FY 23/24	
	Number	Percentage
American Indian / Alaska Native	*	<1%
Asian	*	1%
Black/African American	14	4%
Native Hawaiian / Pacific Islander	*	1%
White	180	51%
More than one race	*	2%
Other	*	1%
Unknown	140	39
Total:	**355**	**100%**

Ethnicity	Individuals Served FY 23/24	
	Number	Percentage
Hispanic or Latino	52	15%
Non-Hispanic or Latino	169	47%
Declined/Unknown	134	38%
Total:	**355**	**100%**

Due to privacy any value <10 has been removed

OUTCOMES:

Outcomes	Number / FY 23/24
# Services Provided Outside of the Office	1091
# Potential Responders Reached	76
# Referrals with a Successful Engagement	106
# Individuals Connected to Community Resources	43

Innovation Projects

In FY 2023-2024, the programs outlined below were in operation:

- NAMI on Campus High School Innovation Plan
- Full-Service Partnership (FSP) Multi-County Collaborative
- Early Psychosis Learning Health Care Network (LHCN) Multi-County Collaborative
- Community Program Planning Innovation Project

Actual program results for the individual programs are found on the following pages.

NAMI on Campus High School Model (NAMI on Campus)

Operated by Stanislaus County Office of Education

PRIMARY PURPOSE:

Increases access to behavioral health services.

CONTRIBUTION TO LEARNING:

This project introduces a new application to the behavioral health system of a promising community- driven practice or an approach that has been successful in a non-behavioral health context or setting.

PROJECT DESCRIPTION:

NAMI on Campus High School Innovation Project seeks to increase access to behavioral health services by applying a proven effective model for youth leadership, development, and organization to advance the behavioral health outreach efforts in high schools throughout Stanislaus County.

The project will integrate the framework of Protecting Health and Slamming Tobacco (PHAST), a program incorporating a strong county-wide coordination of student clubs in Stanislaus County, with NAMI on Campus High School (NCHS) to raise behavioral health awareness and reduce stigma. This collaboration is expected to propel and sustain the local growth of student organizations in high schools, creating a culture shift to train and equip students to improve behavioral health awareness, conduct outreach, increase advocacy and destigmatize mental illness.

STRATEGY:

To introduce NAMI on Campus High School through this innovative framework of county-wide collaboration to high schools in Stanislaus County.

- Develop and sustain dedicated leadership of administrators and faculty club advisors which recruit student members and leaders, provide support and guidance for youth-led operations of club activities, meetings, and events.
- Cultivate student leaders to communicate and educate peers on how to access available behavioral health services in the County, increase knowledge of the signs and symptoms of behavioral health challenges and end the stigma preventing many individuals from seeking help.
- Embrace a culture of youth who are hungry to lead, passionate about building up and improving their community, and genuinely care about helping their peers by providing opportunities for researching, communicating, and advocating for others.
- Conduct annual outreach campaigns addressing topics such as suicide prevention, behavioral health awareness and advocacy.
- Through monthly NCHS Club advisor meetings, build a county-wide collaborative to help strengthen the combined efforts and leverage resources for up to 15 high schools in Stanislaus County.

- Strengthen the collaboration between NAMI Stanislaus, NAMI California and Stanislaus County School Districts by providing a centralized hub for communication, resources and training.

This work will improve access to behavioral health services, reduce stigma related to behavioral health challenges and increase knowledge on the signs and symptoms of behavioral health challenges.

LEARNING PROPOSED:

- Can adopting new and expanded outreach strategies improve overall access for people in need of services?
- Can adopting new and expanded outreach strategies decrease the stigma of behavioral health problems among high school students?
- Will coordinated cross-collaboration among SCOE, NAMI and school districts increase and sustain behavioral health outreach and education at high school campuses?
- Will student participation in behavioral health outreach increase protective factors and improve well-being among high school students?

Through coordinated peer outreach strategies, we anticipate youth will have increased knowledge of the signs and symptoms of behavioral health problems and how to seek services. We also anticipate a positive change in attitudes towards seeking behavioral health services and encouraging others who may need services to seek support.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$208,553	580	$360

PARTICIPANT DEMOGRPAHICS:

NAMI on Campus Clubs in Stanislaus County Club Membership by School	
School (School District)	Count
Beyer High School (Modesto City)	31
Central Catholic High School (Modesto City)	10
Central Valley High School (Ceres USD)	15
Ceres High School (Ceres USD)	100
Denair High School / Denair Charter Academy (Denair USD)	69
Davis High School (Modesto City)	n/a
Downey High School (Modesto City)	17
Enochs High School (Modesto City)	40
Gregori High School (Modesto City)	25
Johansen High School (Modesto City)	39
Hughson High School (Hughson USD	38
Modesto High School (Modesto City)	20
Oakdale High School (Oakdale USD)	12
Orestimba High School (Newman-Crowslanding USD)	40
Patterson High School (Patterson USD)	9
Petersen Alternative Center for Education (Stanislaus COE)	0*
Pitman High School (Turlock USD)	15
Riverbank High School (Riverbank USD)	25
Turlock High School (Turlock USD)	25
Waterford High School (Waterford USD)	50
Total	580

PROJECT UPDATES:

1. **Improving Access to Mental Health Services**

- **Expanding High School Clubs:** NAMI on Campus expanded to 20 high schools in Stanislaus County in 2023-2024, adding new clubs at Beyer, Johansen, Downey, and Waterford High Schools, despite the closure of Valley Charter High School.
- **Addressing Unique Needs*:** Traditional student clubs did not align with the unique environment at Petersen Alternative Center for Education (PACE). Monthly activities were planned for all students at PACE and ensured equitable access to behavioral health education in a nontraditional school setting.
- **Middle School Initiatives:** "Minds Matter" middle school clubs launched at Creekside (Patterson USD), Denair (Denair USD), Prescott (Stanislaus USD), Ross (Hughson USD), and Yolo (Newman-Crowslanding

USD), creating a bridge to high school programs by fostering behavioral health advocacy and a sense of belonging.

- **University Expansion:** NAMI on Campus club was established at California State University, Stanislaus, furthering behavioral health advocacy and resources in higher education.
- **Growth in Membership:** By June 2024, participation across all high school clubs reached almost 600 students, reflecting significant progress in providing behavioral health education and peer-led support to a growing number of youths throughout the region.

2. **Reducing Stigma Through Peer-Led Advocacy**

- **Revamped Monthly Themes:** To enhance the impact of behavioral health education, the Club's monthly themes were completely overhauled, aligning with NAMI California's curriculum, national behavioral health awareness initiatives, and Social Emotional Learning (SEL) competencies. This alignment ensures comprehensive, actionable outcomes for students.

Behavioral Health Monthly Themes:

Month	Theme	Focus Areas (SEL Competencies)
August	Back to School (Friendship; Club Membership Drive)	Positive friendships (Relationship Skills); Improving connection and belonging (Social Awareness)
September	Suicide Prevention (Self-Care; Coping Skills)	Recognizing warning signs (Social Awareness); Seeking help (Responsible Decision-Making)
October	Stigma (Bullying; School Safety; Depression Awareness)	Understanding stigma's impact (Social Awareness); Building safe relationships (Relationship Skills)
November	How to Help a Friend (Friendsgiving; Healthy Relationships)	Effective communication and empathy (Relationship Skills)
December	Families and Mental Health	Understanding family dynamics (Social Awareness); Supporting families (Relationship Skills)
January	Mental Wellness Month (Mindfulness; Affirmations)	Mindfulness for self-awareness (Self-Awareness); Positive self-talk (Self-Management)
February	Mental Health Across Cultures (LGBTQ+; Equity)	Respecting cultural perspectives (Social Awareness)
March	Mental Health Myths and Facts (Education on Illnesses)	Challenging misconceptions (Social Awareness)
April	Careers in Mental Health (Volunteer and Service)	Exploring interests (Self-Awareness); Informed career decisions (Responsible Decision-Making)
May	Mental Health Awareness	Broadening understanding and community support (Social Awareness)
June	LGBTQ+ (Pride Month)	Addressing unique challenges (Social Awareness); Fostering inclusivity (Relationship Skills)
July	Self-Care (Mindfulness and Gratitude)	Developing coping mechanisms (Self-Management)

- **School-Wide Mental Health Campaigns:** Dynamic school-wide campaigns were thoughtfully designed for NAMI on Campus clubs, strategically aligning with monthly behavioral health themes, and incorporating social-emotional strategies to enhance protective factors for all students. These campaigns included: s
    - *The Case of the Missing Mascot: A Friendship Mystery:* A back-to-school behavioral health campaign crafted to promote friendship, belonging, and community through interactive problem-solving and teamwork.
    - *Friendsgiving Progressive Lunch:* Encouraged gratitude, fostered connection, and strengthened relationships through interactive stations and activities.
    - *Myth Buster Café:* Engaged students in activities to dispel harmful behavioral health myths and promote factual understanding, emphasizing education and stigma reduction.
- **Community Partnerships and Advocacy Events:** Clubs collaborated with community organizations to amplify their advocacy efforts and engage in impactful events, including:
    - *Out of the Darkness Suicide Prevention Walk* (with the AFSP): Club members promoting suicide prevention awareness and advocacy.
    - *Ending the Silence* (with NAMI Stanislaus) Educating middle and high school youth about the warning signs of behavioral health conditions and steps to take for supporting a friend or family member.
    - *Annual Blood Drive* (with American Red Cross) Campaign hosted annually by the Orestimba High School NAMI on Campus Club demonstrating community service and leadership.

1. **Building Strong Collaborative Networks**
    - **BreakDown Network Meetings:** Transitioned monthly NAMI Club Advisor meetings into "BreakDown," an online forum connecting behavioral health professionals, counselors, and advisors to share resources and strategies aligned with behavioral health themes.
    - **Community Impact:** Partnerships with NAMI California, NAMI Stanislaus, and Stanislaus County BHRS strengthened resource sharing and activity development.
    - **Events as Catalysts:** Large-scale events like *Fueling Passion Youth Leadership Conference* and *Breaking Barriers Artistic Expression Youth Symposium* united club members across the county in behavioral health advocacy.
    - **Regional and Statewide Recognition:** Program coordinator presented at statewide events, including the California Department of Education's Center for School Climate and the School Boards Association Education Conference, inspiring broader adoption of behavioral health education strategies.
2. **Cultivating Resilience and Leadership**
    - **Youth Empowerment:** Students developed vital leadership and advocacy skills at regional and statewide conferences, such as:
        - *Breaking Barriers: Mental Health and the Transformative Power of Artistic Expression:* The event focused on the intersection of behavioral health, art, and culture. Club members were guided by experienced facilitators, and explored how art serves as a powerful tool for building resilience

and fostering self-care.

- *Fueling Passion: Youth Leadership Symposium:* The collaborative event was hosted with Modesto City Schools and brought students from NAMI on Campus Clubs, Hispanic Youth Leadership Council and Black Student Union together to promote mental well-being and leadership development.
- *NAMI California Advocacy Day & Youth Summit:* Offered club members the opportunity to engage with lawmakers at the California State Capitol through legislative visits, advocating for policies aimed at improving behavioral health care and enhancing quality of life.

- **Advisor Reflections:**
  - "I've watched our students grow from quiet participants into passionate advocates for mental health."
  - "This club has provided many resources for students on our campus and has helped reduce stigma of mental health issues."
  - "School-wide attitudes about mental illness and mental health are much kinder and more informed than in years past."

3. Preparing for Sustainability

- **Focus on Capacity Building:** Through the Innovation Project, Stanislaus COE has demonstrated the critical role of county-wide coordination in supporting NAMI on Campus clubs. By equipping advisors with tailored resources and fostering a sustainable network for collaboration and sharing, the program has laid the groundwork for continued success. This model ensures that while advisors may rely on structured support, the network provides the necessary infrastructure to maintain and grow behavioral health advocacy efforts across the county.
- **Integration with Tier One and SEL Frameworks:** The alignment of monthly behavioral health topics with Tier One strategies and the Social Emotional Learning (SEL) framework has been a cornerstone of this year's work. This integration not only enhances student outcomes but also provides a scalable framework for county-wide behavioral health education.
- **Innovative Resources and Engagement Strategies:** The project prioritizes the development of innovative and responsive resources to meet the evolving needs of students. County-wide coordination paves the way for exploring new engagement strategies, enabling NAMI on Campus clubs to remain relevant and impactful while fostering a culture of creativity and adaptability among students and advisors.
- **Leveraging Partnerships:** Collaborative relationships with organizations such as NAMI California, NAMI Stanislaus, and Stanislaus County Behavioral Health and Recovery Services (BHRS) have played a key role in the program's success. These partnerships provide critical support, amplify the reach of behavioral health initiatives, and align efforts across schools and communities. By leveraging these connections, the program has built a robust foundation of shared resources and expertise that strengthens its ability to sustain impactful behavioral health advocacy in the years ahead.

Full-Service Partnership (FSP) Multi-County Collaborative

Operated by Third Sector

PRIMARY PURPOSE:

Introduces a new practice or approach to the overall mental health system.

CONTRIBUTION TO LEARNING:
This Project increases the quality of behavioral health services, including measured outcomes, and promotes interagency, and community collaboration related to Behavioral Health Services or supports or outcomes.

PROJECT DESCRIPTION
Stanislaus County Behavioral Health Recovery Services (Stanislaus County) is participating in a 4.5-year Multi-County FSP Innovation Project that will leverage counties' collective resources and experiences to implement improvements to Full-Service Partnership (FSP) services across California. This work builds on the work of six initial counties that began the project in 2020 and is in partnership with Third Sector, a national nonprofit technical assistance organization, the Behavioral Health Services Oversight and Accountability Commission (BHSOAC), the California Services Authority (CalMHSA), and the Rand Corporation.

Through participation in this Multi-County FSP Innovation Project, Stanislaus County is implementing new data-informed strategies to program design and continuous improvement for their FSP programs, supported by county-specific implementation and evaluation technical assistance. The overall purpose and goals of the Multi-County FSP Innovation Project are to:

1. Improve how counties define and track priority outcomes and related performance measures, as well as counties' ability to apply these measures consistently across FSP programs
2. Develop new and/or strengthen existing processes for continuous improvement with the goals of improving outcomes, fostering shared learning and accountability, supporting meaningful program comparison, and effectively using qualitative and quantitative data to inform potential FSP program modifications
3. Develop a clear strategy for how outcomes and performance measures can best be tracked and streamlined through various state-level and county-specific reporting tools
4. Develop a shared understanding and more consistent interpretation of the core FSP components across counties, creating a common FSP framework that both reflects service design best practices and is adaptive to local context
5. Increase the clarity and consistency of enrollment criteria, referral, and graduation processes through the development and dissemination of clear tools and guidelines intended for county, providers, and referral partners

STRATEGY

In the first 22-month technical assistance period that began in the Fall of 2021, Stanislaus County has been working with Third Sector as they assess local FSP context and provide targeted, county-specific assistance in implementing outcomes-focused improvements. This technical assistance period is divided into three discrete phases (Landscape Assessment; Implementation; Sustainability Planning):

Phase 1 - Landscape Assessment: The goal of the Landscape Assessment phase is to ensure Stanislaus County has an aligned understanding of the current state of its FSP programs, customized recommendations to create a more data-driven, outcomes-oriented FSP program, and a realistic work plan for piloting new improvements during Phase 2, the Implementation Phase.

Phase 2 - Implementation: During this phase, Stanislaus County designs and pilots new strategies that were developed during Phase 1, with individualized guidance and support from Third Sector. As a result of this phase, Stanislaus County will pilot and begin implementing new outcomes-oriented, data-driven strategies.

Phase 3 - Sustainability Planning: Throughout Phases 1 and 2, Stanislaus County is working closely with Third Sector to ensure sustainability, and that county staff have the capacity to continue any new strategies and practices piloted through this project. Phase 3 provides additional time and dedicated focus for sustainability planning, whereby Stanislaus County works with Third Sector to understand the success of the changes to-date and finalizes strategies to sustain and build on these new data-driven approaches. Stanislaus County may also partner with other counties to elevate project implementation successes to champion broad understanding, support, and continued resources for outcomes-focused, data-driven behavioral health and social services. As a result of Phase 3, Stanislaus County will have a clear path forward to continue building on the accomplishments of the project.

LEARNING PROPOSED

At the end of this project, Stanislaus County will have clearly defined FSP outcome goals that relate to program and beneficiary priorities, well-defined performance measures to track progress towards these outcome goals, and a clarified strategy for tracking and sharing data to support meaningful comparison, learning, and evaluation.

In addition, counties participating in this Innovation Project have co-developed and will participate in concurrent FSP learning communities. County MHSA and FSP staff will engage in an interactive learning process that includes hearing and sharing best practices and developing tools to improve services and outcomes for FSP participants. Third Sector will synthesize and disseminate learnings between counties participating in this Innovation Plan, helping each county to build upon the work of the others and develop a set of recommendations for any state-level changes to FSP requirements and/or data collection practices that are supported by a broad coalition of participating California counties.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost
$210,344

PROJECT UPDATES

During FY 2023-2024, Stanislaus County worked with RAND to initiate the evaluation component of the Learning Project.

RAND FSP Evaluation Summary FY 23-24

RAND is conducting 1) a quantitative analysis of individual-level data provided by counties in order to understand the impact of FSP programs on the individuals served (e.g., changes in key outcomes such as stable housing, healthcare service utilization, criminal justice involvement, etc.), and 2) a qualitative analysis of system-level impacts of the FSP innovation project (i.e., changes to FSP program practices and their perceived impact on providers and individuals served). During FY 23-24, RAND completed the quantitative and qualitative evaluation for the first cohort of counties, detailed in the report: Evaluation of the California Multi-County Full Service Partnership Innovation Project | RAND. Stanislaus is in the second cohort of counties, for which evaluation is currently in progress.

For the quantitative analysis for the second cohort, RAND securely received individual-level DCR and EHR data from Stanislaus and other wave 2 counties in FY 23-24, preparing to clean the data and conduct statistical analyses in FY 24-25. For the qualitative analysis, RAND began recruitment activities for key informant interviews to understand both department of behavioral/behavioral health leadership and “on the ground” provider perspectives on the FSP innovations in FY23-24, but these interviews were completed early in FY 24-25.

With respect to timeline, RAND anticipates completing all analyses for Stanislaus and other counties in the second cohort and releasing the final evaluation report on this group by the end of FY 24-25.

Early Psychosis Learning Health Care Network (LCHN) Multi-County Collaborative

Operated by University of California Davis

PRIMARY PURPOSE:

Increase the quality of mental health services, including measurable outcomes.

CONTRIBUTION TO LEARNING

This Project introduces a mental health practice or approach that is new to the overall mental health system.

PROJECT DESCRIPTION

The Early Psychosis Learning Health Care Network (LHCN) is a multi-year, multi-county innovation project that aims to connects early psychosis (EP) programs across California to improve early identification, diagnosis, clinical assessment, intervention effectiveness, service delivery, and health outcomes in clinics offering evidence-based specialty care to persons in the early stages of psychotic illness. Another major goal of the EP LHCN is to develop a sustainable network of California EP programs via a collaborative statewide evaluation to clarify the effect of the network and these programs on the consumers and communities that they serve. The EP LHCN is led by UC Davis in collaboration with UCSF, UCSD, and multiple California Counties. The initial infrastructure for the LHCN was developed using MHSA Innovation funds and thus the project complies with the regulatory and funding guidelines for evaluation as stipulated by the applicable MHSA funding regulations, contract deliverables, and best practices.

The EP LHCN links multiple early psychosis clinical service programs and create a network using a core assessment battery of valid, low-burden measures and an mHealth technology platform to collect client-level information as part of standard care, visualize such information via clinician dashboard for treatment planning, and integrate across clinics to provide de-identified data for evaluating statewide outcomes data. The core assessment battery includes standard measures of early psychosis clinical features, services, and treatment outcomes.

The EP LHCN network of California (termed “EPI-CAL”) contributes these systematically collected clinical outcomes from participating community and university EP clinics to a national EP network, supported by the NIMH EPINET program. The Early Psychosis Intervention Network (EPINET) is a 5-year project that connects regional hubs to a national network of EP programs. EPI-CAL is California’s regional hub. Data collected within the LHCN requires individuals to make choices about sharing their data outside the clinic, including with UC Davis for the statewide evaluation as part of the Innovation project and to the EPINET National Data Coordinating Center for research. This is optional and data is only be shared if users opt in. The project also includes development and validation of a measure of the Duration of Untreated Psychosis (DUP) that is feasible for use in community settings.

An additional component of the LHCN project is to identify, describe, and analyze the costs incurred by providing early psychosis clinical services, the outcomes associated with such a program, and the costs associated with those outcomes for individuals served by each program in each county. We will also examine services and costs associated with similar individuals served elsewhere in the county. This includes past and current members in the EP program, as well as individuals with similar diagnoses who utilized other behavioral health services in Stanislaus County.

This Statewide EP Evaluation, LHCN, and NIMH EPINET all primarily aim to 1) increase the quality of mental health services, including measurable outcomes, and 2) introduce a mental health practice or approach that is new to the overall mental health system.

STRATEGY

To assess core outcomes in early psychosis programs and improve measurement-based care, the EP LHCN administers a core assessment battery of valid, low-burden measures via a mHealth technology platform (Beehive). The core assessment battery includes standard measures of early psychosis such as measures about symptoms, functioning, quality of life, adverse childhood experiences and traumatic life events, detailed demographic features, and others (please see our core assessment battery on our resource guide: https://sites.google.com/view/beehiveguide/core-assessment-battery).

The core assessment battery is administered via a custom-built application called Beehive (beehiveremote.com) at enrollment and every 6 months and includes consumer self-report measures, as well as support person- and clinic-completed measures. Members can complete surveys about their experiences via personalized weblinks sent to them by their clinical team or on a tablet in the clinic. Providers can also directly input information, such as symptom ratings and treatment progress. This information is designed to be reviewed on the client's dashboard. The visualization of the members' scores can include clinical thresholds, where applicable, and comparative data across all members in the LHCN. Beehive also allows the clinical team to see the breakdown of individual responses and summaries of the services the client has used over time. Beehive provides high level summaries of key clinic data, such as client demographics and service utilization. Beehive also supports data downloads and clinic staff can export data from specific surveys between specific dates and use it as part of county reporting requirements or quality assurance efforts.

The design and approach of the different components of the EP LHCN has been shaped by the input of community partners, including behavioral health consumers and family members. This was accomplished in part by collecting qualitative data from focus groups, community partner meetings, and qualitative interviews with consumers, families, county staff and EP program staff to inform implementation of LHCN and the evaluation, present findings, and assess satisfaction. We are continuing to collect qualitative data via focus groups and interviews, after which we will complete a report summarizing consumer and provider skills, beliefs and attitudes around measurement-based care and use of LHCN in service delivery.

Each LHCN program also participates in a fidelity assessment. Fidelity is the degree of implementation of an evidence-based practice and a fidelity assessment provides a list of objective criteria by which a program or intervention is evaluated to assess the degree to which they adhere to a reference standard for the intervention. For the purpose of the LHCN, our fidelity assessments assess fidelity to the Coordinated Specialty Care Model for Early Psychosis.

For the county-level data component of the LHCN, wherein we identify, describe, and analyze costs incurred by providing early psychosis clinical services, the outcomes associated with such a program, and the costs associated with those outcomes for individuals served by each program in each county, we collect cost and service utilization data from each participating county. This cost and utilization data is harmonized across counties and compared to services and costs associated with similar individuals served outside of the EP program in the counties.

LEARNING PROPOSED

Through the development of the LHCN and the associated evaluation, we propose to answer the following questions:

1. Do consumer and/or provider skills, beliefs, and attitudes about technology or measurement-based care impact completion of LHCN outcome measures or use of data in care?
2. Does engagement in the LHCN impact consumer satisfaction with care, insight into treatment needs, and alliance with the treatment team?
3. Are there differences in utilization and costs between EP programs and standard care?
4. How does utilization and cost relate to consumer-level outcomes within EP programs?
5. What are the EP program components associated with consumer-level short- and long-term outcomes in particular domains?
6. Within EP programs, what program components lead to more or less utilization (e.g., hospitalization)?
7. To what extent to California EP programs deliver high fidelity evidence-based care, and is fidelity related to consumer-level outcomes?
8. What are the barriers and facilitators to implementing and LHCN application across EP services?
9. What are the consumer, family, and provider experiences of submitting and utilizing data obtained through the LHCN during routine clinical care?
10. Does a technology-based LHCN increased use of consumer-level data in care planning relative to a program's prior practice?
11. What is a viable strategy to implement a statewide LHCN for EP programs?

FY 2023-2024 ACTUAL RESULTS:

Actual Cost
$183,398

PROJECT UPDATES

Stanislaus County's LIFE Path program have been active participants in all components of the LHCN described above. They have actively been engaged with enrolling members into Beehive to assess key clinical outcomes. To date, the LIFE Path program has enrolled 36 members into Beehive. Of those, several have completed outcomes measures offered through the core assessment battery. Program staff have also attended several LHCN meetings that promote learning across the network, including our bi-annual LHCN Advisory Committee meeting and first annual EPI-CAL in-person conference that took place in September of 2024. Program staff have also participated in barriers and facilitator interviews that assess Beehive implementation at the program level and given feedback to our staff on development of new features for the Beehive application. As new program staff are onboarded into the LIFE Path program, they have complete EPI-CAL baseline surveys to assess individual-level clinician components that may influence client-level outcomes, as well as accessed trainings through our learning management system, Cornerstone.

During the last project period, we've received the county-level utilization data from Stanislaus County for the county-level data analysis component of the project. We are working closely with Stanislaus County staff as we complete the analysis of this data. We are also working closely with LIFE Path program staff to complete their second fidelity assessment, for which data collection has started but interviews have not yet been scheduled.

Community Program Planning Innovation Project

FY 2023-2024 ACTUAL RESULTS:

Actual Cost
$78,031

Funding for Innovations Community Planning Process and Stakeholder Input
In February 2022, BHRS was approved by the Behavioral Health Services Act Oversight and Accountability Commission (BHSOAC) to earmark use of INN funds for community planning activities involving stakeholders, most directly, individuals in the unserved and underserved communities of Stanislaus County. These planning funds are to specifically support the design, development and implementation of new INN ideas brought forth through the CPP.

Stanislaus County BHRS received authorization to use 5% of the Innovations funding over the next five years to direct towards community planning.

In FY 2023-2024, BHRS had CPP partnerships with several diverse community partners including the Central California LGBTQIA+/2S Collaborative, the Assyrian Wellness Collaborative, La Familia, MoPride Inc. and Sierra Vista all who conducted focus groups throughout the community to help facilitate conversations around behavioral health need and services and provided those insights to the Department.

The following are some themes that were identified by CPP partners:

Community Engagement Summary – Central California LGBTQIA+ Collaborative

The Central California LGBTQIA+ Collaborative held five events aimed at fostering community engagement and addressing behavioral health needs within the LGBTQIA+ population. These included:

- 2 focus groups to gather in-depth community input
- 3 community events focused on sharing vital resources, with behavioral health support as a key topic

Partner Organizations:

- CalPride Stanislaus
- West Modesto Community Collaborative
- El Concilio
- City of Riverbank

Identified Barriers to Behavioral Health Access:

Participants identified multiple systemic and social barriers that impact access to behavioral health care:

- Difficulty finding LGBTQ+ affirming providers
- Insurance challenges, including high costs or lack of coverage
- Long wait times and limited provider availability

- Fear of discrimination or stigma, especially in clinical settings
- Lack of specialized services tailored to LGBTQ+ needs

Key Takeaways & Recommendations:

- Increase cultural awareness and sensitivity within behavioral health services
- Promote diversity among providers and staff to better reflect the community
- Encourage organizations to visibly identify as allies (e.g., through inclusive signage, public commitments)

Community Engagement Summary – La Familia – Alta Tu Voz (Raise Your Voice)

- 12 focus groups, 8 different cities/towns
- 318 participants
- 23 zip codes
- 154 surveys conducted between September 2023-June 2024

Key Takeaways & Recommendations:

While there are no easy solutions to the behavioral health epidemic that exists across the nation, including in Stanislaus County, below are key takeaways and recommendations based on what La Familia heard from the 318 community members engaged in "Alza tu Voz". The following six recommendations provide tangible steps that would make a lasting impact on the behavioral health of Stanislaus County community members today and in the future.

- Rural communities such as Grayson, Patterson, Riverbank, and Oakdale have unmet needs when it comes to behavioral health. Funding Community/family resource centers and the work of Promotoras provides support that the community responds to and is asking for. In partnering with community promotoras we were able to see the positive impact that they provide to the families that they serve. Their contributions to the communities such as educating them about behavioral health and linking them to behavioral health agencies including BRHS is crucial to preventing behavioral health crises.
- Getting services directly to communities. Having mobile therapists that travel to the more rural communities consistently would alleviate a lot of the transportation problems that individuals face. It would also help to alleviate the timely access to care that many complained about. Additionally, having a psychiatrist available to rural communities is essential for prescription medications and evaluations.
- Support groups help to build community. Community and family are core values in the Latino community, and that is no different when it comes to behavioral health. While some may not seek out individual behavioral health services, support groups may be more acceptable. Having cultural competency and humility is essential to providing a safe environment in which people can discuss and be validated about the struggles that they may be facing.
- Raising awareness and reducing stigma. Informing the community about resources allows them to know about programs available to them and it allows them to support others when they need help. It is essential to educate the community in regard to "red flags" in behavioral health, that way people can know when and where to seek help for their loved ones.
- Behavioral Health Urgent Care. Having a place where people could be triaged when having suicidal ideation such as a Behavioral Health Urgent Care would be extremely beneficial for the community as a whole as

many are scared to go to the hospital or to call 911. This resource would be more accessible in the eyes of the community and could provide low/no-barrier crisis care that does not currently exist.
- Bilingual services are important. Spanish speaking staff, Clinicians, and Psychiatrists are essential to providing care to the Latino community. Participants stressed that receiving care in their preferred language improved their experiences as well as their results. While many Latino youth may prefer services in English, most reported that their parents/guardians preferred Spanish, and it was best when the Clinician was able to communicate with both.

Community Engagement Summary – Stanislaus Asian American Community Resource (SAACR)

Two culturally focused community events were held to engage Asian American families in Stanislaus County:

- SAACR Asian American Family Graduation
- SAACR Asian American Family Wellness Picnic

These events successfully gathered feedback from the community on awareness of BHRS and mental health services, and whether they or someone they know has experienced behavioral health challenges. A total of 85 surveys were completed with the following results:

Awareness of Behavioral Health and Recovery Services (BHRS)

- 51% of participants reported they had heard of Stanislaus County BHRS.
- 49% had never heard of BHRS.

Perception of Behavioral Health in the Community

- 40% said they know or think they know someone experiencing behavioral health challenges.
- 60% said they do not or are unsure if they know someone with such challenges.

Key Takeaways & Recommendations:

Community awareness of BHRS is relatively balanced, but nearly half the participants remain unaware. There is an opportunity for increased outreach and education, particularly within Asian American communities. Additionally, there may be stigma or limited awareness surrounding behavioral health issues in the community. The high level of uncertainty suggests the need for more culturally appropriate education to normalize conversations around behavioral health.

BHRS is committed to leveraging these insights and others gathered by our community partners as input into our community planning process and to inform future program planning through the lens of how to enhance outreach and engagement of programs and services within our diverse, unserved/underserved communities.

Workforce Education and Training (WE&T)

PROGRAM DESCRIPTION

The Workforce Education and Training (WE&T) component of MHSA provides funding to help improve and build the capacity of the behavioral health workforce. It is designed to help counties develop and maintain a competent and diverse workforce capable of effectively meeting the behavioral health needs of the public. WE&T funds are a one-time allocation and do not provide direct service.

The goal is to develop a diverse and well-trained workforce skilled in delivering a culturally competent integrated service experience to members and their families. Equally important are community collaboration efforts to increase protective factors.

Stanislaus County has 4 WE&T Programs

- Workforce Staffing
- Training/Technical Assistance
- Mental Health Career Pathways
- WET Central Region Partnership

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$911,956	6,787	$134.37

WE&T Workforce Staffing

Operated by Stanislaus County Behavioral Health and Recovery Services

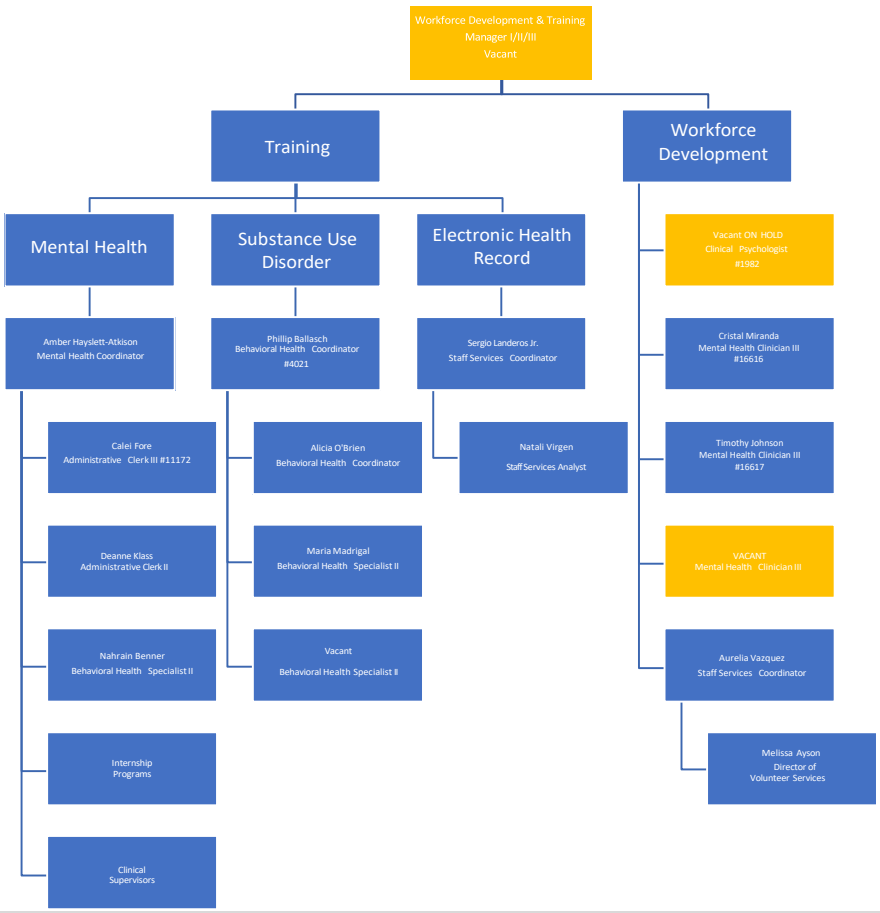
PROGRAM DESCRIPTION

The Workforce Development and Training Division is responsible for the training plan and supporting activities for all department and contracted programs; clinical supervision; continuing education and provider association enrollment and management; internship programs; volunteer programs; and workforce development activities, including but not limited to, career development, undergraduate and graduate educational partnerships, scholarship, loan repayment, stipend programs, and workforce retention activities.

SERVICES AND ACTIVITIES

Stanislaus County Behavioral Health and Recovery Services is committed to the training and development of all its employees in order to ensure the consistent delivery of quality services to all customers, members, peers and community partners. The aim of the Workforce Development and Training Department is to embrace best practice and is demonstrating this commitment by striving to develop its continuous learning and professional development. The four main responsibilities are training, workforce development, workforce education and the volunteer program.

WE&T WORKFORCE STAFFING PROGRAM PARTICIPANT DEMOGRAPHICS:



Staffing Structure: Training Plan & Activities	Positions
Manager	1 (Vacant)
Mental Health Coordinator	1
Staff Services Coordinator	1
Behavioral Health Coordinator	1
Behavioral Health Specialist	3 (1 Vacant)
Staff Services Analyst	1
Staffing Structure: Workforce Development	**Positions**
Clinical Psychologist	On Hold
Behavioral Health Clinician III	3 (1 Vacant)
Staffing Structure: Volunteer Program	**Positions**
Staff Services Coordinator	1
Director of Volunteer Services	1
Staffing Structure: Support	**Positions**
Administrative Clerk III	1
Administrative Clerk II	1

WE&T Training/Technical Assistance

Operated by Stanislaus County Behavioral Health and Recovery Services

PROGRAM DESCRIPTION

Training focuses on core competency, general clinical skills and knowledge, and core treatment model services. Workforce development focuses on partnerships with learning institutes/presenters and providing program-level technical skill enhancement.

SERVICES AND ACTIVITIES

The Workforce Development and Training Department can develop and deliver customized training courses that meets the goals of Stanislaus County Behavioral Health and Recovery Services. The department ensures all instructors are knowledgeable and qualified, that course content criteria and diversity, equity and inclusion values are met, and if applicable that continuing educational credits are offered.

FY 2023 – 2024 Live Trainings Data Report Results:

- Trainings Provided 2023-2024: **111**
- Training Hours for Participants: **1,205**
- Total Continual Education Hours: **684.30**
- BHRS Staff Attendance/Participation: **1,935**
- Contractor Staff Attendance/Participation: **922**

FY 2023 – 2024 Online Trainings Data Report Results:

- Trainings Provided 2023-2024: **75**
- Training Hours for Participants: **188.30**
- Total Continual Education Hours: **0.00**
- BHRS Staff Attendance/Participation: **2,415**
- Contractor Staff Attendance/Participation: **159**

WE&T Mental Health Career Pathways

Operated by Stanislaus County Behavioral Health and Recovery Services

PROGRAM DESCRIPTION

The Workforce Development and Training Division specifically is designed to meet the goal of developing multicultural, diverse, and recovery-oriented behavioral health workforce. The goal is to provide core training in the values and principles of psychosocial rehabilitation and the skills necessary to provide hope-filled, values-driven services.

SERVICES AND ACTIVITIES

Workforce Education focuses on cultural competency trainings, internships/practicums, and continuing education opportunities. The Volunteer Program focuses on community engagement, skill building/job opportunities and California Association of Social Rehabilitation Agencies (CASRA).

Psychosocial Rehabilitation

MJC's California Association of Social Rehabilitation Agencies (CASRA) based program provides a structure to integrate academic learning into real life field experience in the adult public behavioral health system. Before the partnership was established with BHRS, MJC did not have a Psychosocial Rehabilitation (PSR) curriculum. The initiative taken by SCBHRS to purchase the CASRA curriculum signifies an effort to fill the gaps for employment of consumers and family members. Students who have received a Psychosocial Rehabilitation Skills Recognition Certificate are eligible for the State Psychosocial Rehabilitation certification after completing a minimum of 2,500 field experience hours.

The Psychosocial Rehabilitation Program at MJC is a twelve (12) unit curriculum with two (2) additional courses recommended for success, totaling fifteen (15) unit. Courses provide individuals with the knowledge and skills to apply goals, values, and principles of recovery- oriented practices to effectively serve consumers and family members. The certificated units also count towards an Associate of Arts (AA) Degree in Human Services at MJC. Participants of the CASRA program can receive a stipend from BHRS to assist with school fees, parking passes, and school supply vouchers, as needed. The program also offers a textbook loan program.

CASRA program participants receive ongoing peer support and academic assistance to maximize their opportunities for success.

OUTCOMES:

CASRA/ Volunteers	**Participants:**
Modesto Junior College	10
Volunteers	13

WE&T Outreach and Career Academy

Operated by West Modesto King Kennedy Neighborhood Collaborative

PROGRAM DESCRIPTION

Outreach and Career Academies were established in response to strong community input to outreach to junior high and high school students to raise awareness about behavioral health and behavioral health careers. One community-based organization participated in the project.

The West Modesto King Kennedy Neighborhood Collaborative (WMKKNC) sponsored the Mark Twain Junior High Wellness Project. As part of their learning, students participated in skits, scenarios, and discussions on issues important to them such as stress, self-esteem, and healthy relationships. They also learned how these issues can affect their physical and mental well- being. A total of five (5) students participated in the project which also introduced them to career opportunities in behavioral health.

Fund Amount	Actual Cost	Total Number of Students
$5,000	$4,649.35	5

WE&T Central Region Partnership

Operated by Stanislaus County Behavioral Health and Recovery Services

PROGRAM DESCRIPTION

The Central Regional Partnership through the Mental Health Services Act Workforce Education and Training (WET) Program has developed a Loan Repayment Program (LRP) and Retention Program opportunity. Stanislaus County, in collaboration with other counties in the region, has partnered with the California Mental Health Services Authority (CalMHSA) and the California Department of Health Care Access and Information (HCAI) to make this funding available to educational students in exchange for service obligations to the Public Mental Health System (PMHS). It will award up to $12,000 to qualified behavioral health service staff, also referenced as providers, within the Region's Behavioral Health provider network that commit to a 12-month full- time service obligation in a recognized hard-to-fill or hard-to-retain position. Through this program, the Central Regional Partnership seeks to support its qualified behavioral health service providers that serve the most underserved populations within the county and work in the most hard-to-retain positions. The Loan Repayment Program was implemented in the fall of 2022 and the Retention Program was implemented in the fall of 2023.

SERVICES AND ACTIVITIES

The Loan Repayment and Retention Programs are financial incentive strategies that are included in the Statewide MHSA WET Plan. It is designed to retain behavioral health professionals who reflect the population's served and share the same ethnic, cultural, and linguistic backgrounds of the communities served. Through this program Stanislaus Behavioral Health and Recovery Services seek to support qualified employees who meet eligibility requirements and commit to a 12-month service obligation.

Eligible provider roles for the program are:

• Licensed Clinical Social Worker	• Licensed Medical Doctor
• Associate Clinical Social Worker	• Psychologist, either doctoral degree or doctoral degree pre-licensed
• Licensed Marriage and Family Therapist	• Licensed Clinical Pharmacist
• Associate Marriage and Family Therapist	• Psychiatric Behavioral Health Nurse Practitioner
• Licensed Professional Clinical Counselor	• Nursing Personnel including LVN, Psych Techs, RN and related job titles
• Associate Professional Clinical Counselor	• Phlebotomist
• Behavioral Health Worker	• Case Manager, Rehabilitation Specialist, or related job titles

Applicants	Awarded	Total Amount Per Person	Service Obligation	Total Awarded
64	39	$12,000	12 months	$468,000.00

WE&T Internships

Operated by Stanislaus County Behavioral Health and Recovery Services

PROGRAM DESCRIPTION

The Workforce Development and Training Division specifically is designed to meet the goal of developing multicultural, diverse, and recovery-oriented behavioral health workforce. The goal is to provide core training in the values and principles of psychosocial rehabilitation and the skills necessary to provide hope-filled, values-driven services.

SERVICES AND ACTIVITIES

Workforce Education focuses on cultural competency trainings, internships/practicums, and continuing education opportunities. Internships provide practical exposure that bridges the gap between academic knowledge and hands on experience. Interns learn to navigate clinical settings, interact with members, and apply therapeutic techniques in supervised environments.

Internships allow individuals to develop essential skills, such as empathy, active listening, crisis intervention and case management. The students are working side-by-side with professionals using evidence-based modalities and the latest research to treat our members. Internships provide opportunities to connect with mentors, supervisors, and colleagues, which can lead to job offers and professional recommendations. The goal is to then have the students apply for full time positions within the county once their schooling is completed.

OUTCOMES:

Internships/Practicums	Participants: FY 23-24
Stanislaus State University	10
Capella University	0
Arizona State University	1
University of Massachusetts – MFT	0
Modesto Jr. College	0

Capital Facilities and Technological Needs

In FY 2023-2024, the programs outlined below were in operation:

- SU-01 Electronic Health Record (HER) System
- SU-02 Consumer Family Access to Computing
- SU-03 Electronic Health Data Warehouse
- SU-04 Document Imaging
- SU-05 New Electronic Health Record System
- SU-06 New Infrastructure

Actual program results for the individual programs are found on the following pages.

SU-01 Electronic Health Record (EHR System)

Operated by: Stanislaus County Behavioral Health and Recovery Services

PROGRAM DESCRIPTION

Technological Needs projects focus on providing the necessary technological tools and processes to modernize how the behavioral health system securely accesses, uses, and stores information. The project supports the empowerment of behavioral health staff, members, and families by providing them with greater appropriate access to technology in order to use information to make critical decisions. By keeping information systems updated, technology serves to improve the quality and coordination of care, operational efficiency, and cost effectiveness.

SERVICES AND ACTIVITIES

- Support of the Electronic Health Record (EHR) trainings by coordinating the use of the computer training room, scheduling assistors, and facilitating access
- Technological maintenance of the EHR system that supports access to and functionality of HER
- Maintenance of EHR accounts
- Facilitation and troubleshooting of technical issues and connection with EHR provider (Cerner)

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$254,419	1,101	$231

SU-02 Consumer Family Access

Operated by: Stanislaus County Behavioral Health and Recovery Services

PROGRAM DESCRIPTION

Technological Needs projects focus on providing the necessary technological tools and processes to modernize how the behavioral health system securely accesses, uses, and stores information. The project supports the empowerment of behavioral health staff, members, and families by providing them with greater appropriate access to technology in order to use information to make critical decisions. By keeping information systems updated, technology serves to improve the quality and coordination of care, operational efficiency, and cost effectiveness.

SERVICES AND ACTIVITIES

- Training and support provided by technicians hired to provide technology assistance to consumers and families
- Individual and group sessions to provide computer assistance for consumers and families to access resources and information

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$30,137	N/A	N/A

SU-03 Electronic Health Data Warehouse

Operated by: Stanislaus County Behavioral Health and Recovery Services

PROGRAM DESCRIPTION

Technological Needs projects focus on providing the necessary technological tools and processes to modernize how the behavioral health system securely accesses, uses, and stores information. The project supports the empowerment of behavioral health staff, members, and families by providing them with greater appropriate access to technology in order to use information to make critical decisions. By keeping information systems updated, technology serves to improve the quality and coordination of care, operational efficiency, and cost effectiveness.

SERVICES AND ACTIVITIES

- Regulatory compliance and continuous research and development
- Continuous development and updating of databases to create views for data analysis and reports.
- Creation of interactive Sequel Server Reporting Services (SSRS) reports to assist in making decisions.
- Data warehouse Architecture, design, and repository
- Remote data process monitoring and notification systems.
- Continuous training and development of EHR database tables, views, and security.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$0	N/A	N/A

SU-04 Document Imaging

Operated by: Stanislaus County Behavioral Health and Recovery Services

PROGRAM DESCRIPTION

Technological Needs projects focus on providing the necessary technological tools and processes to modernize how the behavioral health system securely accesses, uses, and stores information. The project supports the empowerment of behavioral health staff, members, and families by providing them with greater appropriate access to technology in order to use information to make critical decisions. By keeping information systems updated, technology serves to improve the quality and coordination of care, operational efficiency, and cost effectiveness.

SERVICES AND ACTIVITIES

- Daily scanning of behavioral health plan referrals to client charts
- Daily scanning of lab results to client charts

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$0	N/A	N/A

SU-05 New Electronic Health Record System

Operated by: Stanislaus County Behavioral Health and Recovery Services

PROGRAM DESCRIPTION

Technological Needs projects focus on providing the necessary technological tools and processes to modernize how the behavioral health system securely accesses, uses, and stores information. The project supports the empowerment of behavioral health staff, members, and families by providing them with greater appropriate access to technology in order to use information to make critical decisions. By keeping information systems updated, technology serves to improve the quality and coordination of care, operational efficiency, and cost effectiveness.

SERVICES AND ACTIVITIES

- Facilitation and troubleshooting of technical issues and connection with EHR provider (SmartCare)
- Facilitating interoperability data exchange needs with regional Health Information Exchange HIE/Qualified Health Information Organizations.
- Continuous development and use of EHR synthesized data to create views for data analysis and reports.
- Creation of interactive Sequel Server Reporting Services (SSRS) reports and dashboards to assist in making decisions.
- Support Electronic Health Record (EHR) trainings by coordinating the use of the computer training room, scheduling assistors, and facilitating access to data and workflows.
- Maintenance of the EHR system, access/permissions, and functionality of EHR.
- Development of business rules and creating a highly effective data model
- Improved mechanism for the utilization of agile approach to data development
- Data Governance & Policy advising regarding relevant statewide requirements, Project Management and Coordination.
- Provide API Accessibility for the purposes of connecting through qualified third-party applications.
- Data quality testing and validation, and data delivery

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$1,253,379	N/A	N/A

SU-06 New Infrastructure

Operated by: Stanislaus County Behavioral Health and Recovery Services

PROGRAM DESCRIPTION

Technological Needs projects focus on providing the necessary technological tools and processes to modernize how the behavioral health system securely accesses, uses, and stores information. The project supports the empowerment of behavioral health staff, members, and families by providing them with greater appropriate access to technology in order to use information to make critical decisions. By keeping information systems updated, technology serves to improve the quality and coordination of care, operational efficiency, and cost effectiveness.

SERVICES AND ACTIVITIES

- Provide scalable, fast, and secure dev and test environments for outcome data sources.
- Upgraded Servers with improved database maintenance and back-up.
- Data quality testing and validation, and data delivery
- Develop policies and procedures for supporting the timely and frequent exchange of Member information and data.
- Facilitate data archiving and continuously reviewing data governance practices.
- Identify necessary data elements and protocols for direct data exchange between BHRS and MCPs.
- Produce non-proprietary structured format data for interoperability deliverables.

FY 2023-2024 ACTUAL RESULTS:

Actual Cost	Total Number of Participants	Estimated Cost Per Participant
$1,098,546	N/A	N/A

FY 2023-2024 Revenue and Expenditure Report

The FY 2022-2023 Revenue and Expenditure Report (RER) was completed and submitted to DHCS as required by MHSA regulation. The complete RER can be found here: Stanislaus County BHRS MHSA FY 2023-2024 RER.

A printed copy of the RER can also be requested by calling the MHSA Policy and Planning Office at (209) 525-6247.

Community Program Planning Process

Welfare and Institutions Code (W&IC) Sections 5813.5(d), 5892(c), and 5848 define the Community Program Planning (CPP) Process and is the process to be used by the County to develop the Three-Year Program and Expenditure Plans ("Plan"), Annual Updates, and Plan Updates ("Update") in partnership with stakeholders to:

- Identify community issues related to mental illness resulting from a lack of community services and supports, including any issues identified during the implementation of the Mental Health Services Act
- Analyze the behavioral health needs in the community
- Identify and re-evaluate priorities and strategies to meet those behavioral health needs

Each Plan and Update shall be developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans' organizations, providers of alcohol and drug services, health care organizations, and other important interests.

Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on behavioral health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations.

A draft Plan and Update shall be prepared and circulated for review and comment for at least 30 days to representatives. The Stanislaus County Behavioral Health Board (BHB) (established pursuant to Welfare and Institutions Code § 5604) shall conduct a public hearing on the draft Plan and Update at the close of the 30-day comment period. Each adopted Plan and Update shall include any substantive written recommendations for revisions and summarize and analyze any such recommendations for revisions (Welfare and Institutions Code § 5848). Completed documents must be submitted to the Department of Health Care Services (DHCS) and the Behavioral Health Services Oversight and Accountability Commission (BHSOAC) within 30 days after adoption by the Stanislaus County Board of Supervisors and posted on the Stanislaus County BHRS MHSA website.

Local Review

Over the years, planning by BHRS for MHSA funds has included collaborative partnerships with local community members and agencies. Several key elements are central to the mission of BHRS to be successful in these processes, strive to present information as transparently as possible, manage expectations in public planning processes related to what can reasonably and legally be done within a government organization, follow the guidelines given by the State, honor community input, ensure that when plans are posted for public review and comment, stakeholders can recognize community input in the plan, post documents and conduct meetings in understandable language that avoids use of excessive technical jargon and provides appropriately fluent speakers for diverse populations when needed.

Compelling community input obtained at the original launch of MHSA community planning in 2005 developed core guiding principles that serve to inform all subsequent planning processes. Whenever feasible, MHSA plans, processes, and programs should address inclusion and service to all age groups and all geographic areas of the county, be based on existing community assets, not exceed the community's or BHRS' capacity to sustain programs and be compatible with the statutory responsibility BHRS holds to administer MHSA funds organizationally or fiscally.

MHSA Advisory Committee

The MHSA Advisory Committee ("Committee") is actively engaged in identifying needs, priorities, and guiding principles during planning processes. The Committee is comprised of approximately 40 individuals representing a diverse spectrum of community interests in accordance with MHSA guidelines from the following groups and communities listed below.

Consumer and Family Members

- Consumer Partners: Adult
- Family Member Partners: Children
- Family Member Partners: Adult
- Consumer Partners: Transition Age Young Adult (TAYA)
- Consumer Partners: Older Adults
- Family Member Partners: TAY Consumer Partners: Transition Age Young Adult (TAYA)

MHSA Priority Populations

- African American
- Rural
- Assyrian
- Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ)
- Spanish/Latino
- Criminal Justice Involved
- Southeast Asian

Contract Providers of Public Behavioral Health (BH)/Substance Use Disorder (SUD) Treatment Services

- Behavioral Health: Adult
- SUD Services: Adult
- Behavioral Health: Children
- SUD Services: Youth

Collaborative Treatment Partners

- Community Assessment, Response and Engagement (CARE)
- Stanislaus County Community Services Agency (CSA)
- Health Care: Managed Care Plans
- Senior Service Providers
- Stanislaus County Probation
- Modesto Police Department (MPD)
- Housing Providers
- Courts/Judge
- Social Services/Family Resource Centers (FRC)
- Shelters

- Stanislaus County District Attorney

Collaborative Partners

- Philanthropy
- Health Care: Federally Qualified Health Center (FQHC)
- Health Care: Stanislaus County Health Services Agency (HSA)
- Behavioral Health Board (BHB) Member
- Education: K-12
- Education: California State University Stanislaus (CSUS)
- Faith Based Organizations
- Veteran Service Organizations
- Stanislaus County Chief Executive Office (CEO)
- Education: Modesto Junior College (MJC)

Committee member's role includes giving input on all plans and updates to be submitted, reviewing outcome data in the annual update, and sharing information about MHSA plan processes and results with the constituency/community they represent.

FY 2023-2024 CPP Activities

July 19, 2023 – MHSA Advisory Committee Meeting

An MHSA Advisory Committee was held on July 19, 2023, and was open to the public and had 29 attendees. The meeting consisted of overviewing BHRS Strategic Initiatives, The Three-Year Program and Expenditure Plan for FYs 2023-2026, Governor Newsom's proposed changes to modernize the Behavioral Health System, and FY 2023-2024 Program and Expenditure Plan.

August 23, 2023 – MHSA Advisory Committee Meeting

An MHSA Advisory Committee was held on August 23, 2023, and was open to the public and had 32 attendees. The meeting consisted of overviewing the proposed SB 326 legislation and the Community Planning Process.

September 27, 2023 – MHSA Advisory Committee Meeting

An MHSA Advisory Committee was held on September 27, 2023, and was open to the public and had 28 attendees. The meeting consisted of overviewing Community Planning Program Innovations, the Community Planning Process and the Proposed SB 326 legislation.

April 24, 2024 – MHSA Advisory Committee Meeting

An MHSA Advisory Committee was held on April 24, 2024, and was open to the public and had 40 attendees. The meeting consisted of overviewing BHRS Strategic Initiatives, The Program and Expenditure Plan for FY 2024-2025 and Annual Update for FYs 2022-2023 and a Proposition 1 update.

December 18, 2024 – MHSA Advisory Committee Meeting

An MHSA Advisory Committee was held on December 18, 2024, and was open to the public and had 68 attendees. The meeting was hosted in person with a hybrid Zoom option. The agenda consisted of overviewing BHRS/BHSA Staffing Structure, a presentation on the Embedded Health Mental Health Services Team Innovation Project, an update on the Suicide Prevention Education Coalition and an overview of Behavioral Health Transformation.

Local Review of Annual Update for FY 2025-2026

An MHSA Advisory Committee is scheduled for April 30, 2025. Advisory Committee members will receive a detailed presentation of the draft Annual Update for FY 2023-2024 and an overview of the Program and Expenditure Plan for FY 2025-26.

Comments will be solicited through a Comment Form attached at the end of the draft Annual Update document, and will be accepted in the following manner:

- Faxed to (209) 558-4326
- Sent via U.S. mail to 1130 12th St., Suite B, Modesto CA 95354
- Sent via email to bmhsa@stanbhrs.org
- Provided by calling (209) 525-6247

The draft Annual Update will be posted for 30-day Public Review on April 23, 2025. Notification of the public review dates and access to copies of the draft Annual Update will be made available through the following methods:

- An electronic copy of the Annual Update was posted on the County's MHSA website: www.stanislausmhsa.com.
- Paper copies of the Annual Update were delivered to Stanislaus County Public Libraries
- Electronic notification was sent to all BHRS service sites with a link to www.stanislausmhsa.com, announcing the posting of the Annual Update
- MHSA Advisory Committee, Behavioral Health Board members, as well as other community stakeholders were sent the Public Notice informing them of the start of the 30-day review, and how to obtain a copy of the Annual Update
- Public Notices were posted in newspapers throughout Stanislaus County. The Public Notice included access to the Annual Update on-line at www.stanislausmhsa.com and a phone number to request a copy of the document.
-

A public hearing was conducted by the Stanislaus County Behavioral Health Board and held at the Stanislaus County Veteran's Center, 3500 Coffee Rd, Suite 15, Modesto, CA 95357 in the main ballroom on May 22, 2025, at 5 p.m. Community stakeholders were invited to participate.

The public comment period concluded on May 22, 2025. Feedback and questions received during the Public Comment period are noted on the BHRS Public Comment Log on pages 193-195.

The MHSA Annual Update for FY 2025-2026 is targeted to be presented to the Stanislaus County Board of Supervisors on June 10, 2025. The Board of Supervisors meeting will be held at 9:30 a.m. in the Chambers – Basement Level, 1010 10th Street, Modesto, CA 95354.

BHRS Public Comment Log
Annual Update for FYs 2025-2026

The following table represents all comments received by stakeholders and community members during the Public Comment period between April 23, 2025, and May 22, 2025. The Table also notes any revisions made to the Annual Update for FY 2025-2026.

Comment/ Feedback Provided By	Date Comment/ Feedback Received	Page Number	Added/Revised	Date Comment/ Feedback Resolved
Behavioral Health Board Public Hearing	5/22/25	N/A	N/A Questions received: 1. Will staff that have to relocate due to BHSA changes have help to adjust to new positions 2. Will individuals and families be affected by BHSA changes 3. Will the new BHSA reports have a 30 public comment period 4. How will the goals mentioned be measured 5. What will happen with the promotoras program in FY 26-27 6. What happens to the collaborative partners in this process 7. Seems all changes should be handled before these changes take place 8. What can be done to prevent losing program like the promotoras 9. What can we do to save the programs that help our communities that help our families	5/22/25. All Questions were addressed in meeting and noted internally.

			10. Can we do something to revert measure 1 11. Staffing is an existing challenge and now with BHSA it seems like we have a need for administration, and we need to be watchful of pulling staff away from direct staff services 12. BHRS services could benefit more if we focus on education rather than services. Prescribing medications leads to addiction. 13. Could we find a way to create less expensive housing 14. Will we be considering housing in other areas that are not in Modesto 15. Can BHRS provide services to give people certainty in these uncertain times such as immigration law, job search, education, technology training 16. What are the opportunities for collaboratives to keep funds under BHSA	
SCBHRS Staff	5/22/25	Pg. 18	Estimated MHSA Funding Allocation for FY 25-26 additional budget narrative added for context.	5/22/25
SCBHRS Staff	5/22/25	Pg. 12	Workforce Development and Training data added to program detail.	5/22/25
SCBHRS Staff	5/22/25	Pg. 12	Innovation data added to program detail.	5/22/25

SCBHRS Staff	5/22/25	Pgs. 25-27	Fiscal Tables updated to account for a rounding error.	5/22/25
SCBHRS Staff	5/22/25	Pg. 173	WET data has been updated to reflect most recent outcome data.	5/22/25
SCBHRS Staff	5/16/25	Pgs. 98-101	GSD Housing Placement Assistance data has been updated to reflect most recent demographic and outcome data.	5/16/25. Program Narrative updated in Annual Update.
MAC meeting	4/30/25	Pgs. 167-169	Innovations: Community Program and Planning: Can data collected from the CPP & Stakeholders be shared?	5/19/25. Summary of data added to Annual Update.
MAC meeting	4/30/25	N/A	Would like to see integration of binary gender identity for federal vs binary/non-binary California policies	Noted internally.
MAC Meeting	4/30/25	N/A	Youth SUD services for BHRS members. In Stanislaus County there's only one SUD program through CHS however it will be beneficial for BHRS to initiative this service.	Noted internally.
MAC Meeting	4/30/25	N/A	Embedded Neighborhood Innovation project. Is not included. Where is this information for it?	4/30/25. Project commenced in FY 2024-2025.