VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Mental Health Services Act (MHSA)

Annual Update for Fiscal Year 2024-2025

Loretta L. Denering, DrPH, MS
Director
Ventura County Behavioral Health

Connie Moreno-Peraza, LCSW
Assistant Director
Ventura County Behavioral Health

Jason Cooper, M.D.
Medical Director

MENTAL HEALTH SERVICES ACT
PROPOSITION 63
CALIFORNIA

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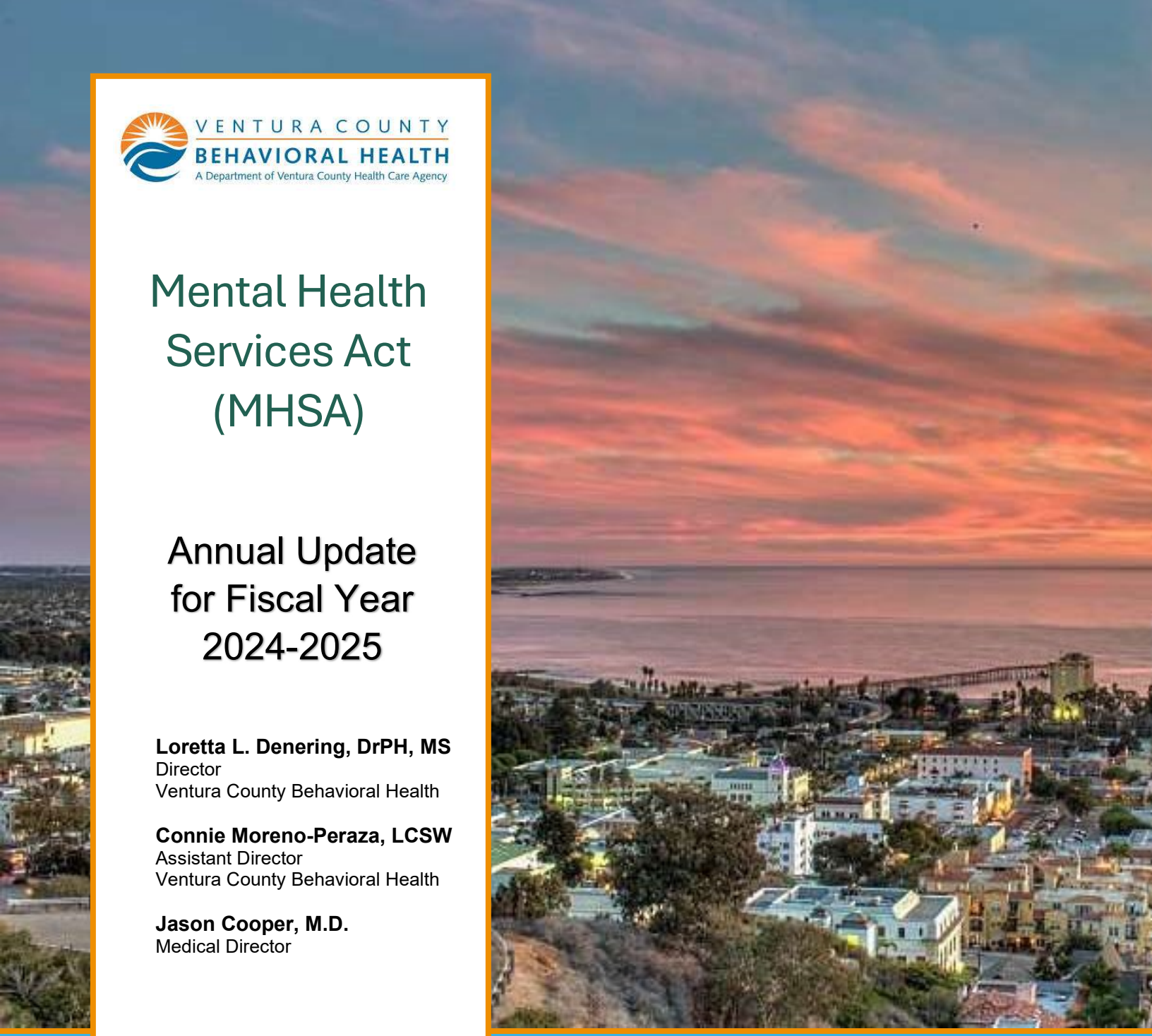

Acknowledgements

The Ventura County Behavioral Health (VCBH) Department would like to acknowledge all individuals and organizations who contributed their time and effort to support the development of this Mental Health Services Act (MHSA) Annual Update.

Thanks to all VCBH staff and outsourced MHSA providers for the excellent services they provide, their continued support with respect to data collection, ensuring clients' voices are heard, and their efforts in bringing this report to fruition.

We especially want to thank our diverse stakeholders, individuals, and groups for participating in various focus groups, evaluation, and planning efforts; all of which help ensure we serve and assist our Ventura County Community in an equitable manner; always striving to better address disparities.

In addition, we would like to thank the VCBH Contracts, Quality Improvement, and Fiscal teams for their contribution, support, and cooperation in gathering the necessary data and information for this report. We would like to acknowledge and thank the VCBH Data Collection and Reporting team for their professionalism and expertise in extracting and preparing the necessary reports. We also acknowledge and thank EVALCORP Research & Consulting for the preparation of the Prevention and Early Intervention (PEI) Evaluation Report.

Finally, we would like to recognize the MHSA Team for its leadership and support in aligning the State reporting and evaluation requirements while valuing stakeholder input and maintaining transparency.

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VENTURA COUNTY BEHAVIORAL HEALTH
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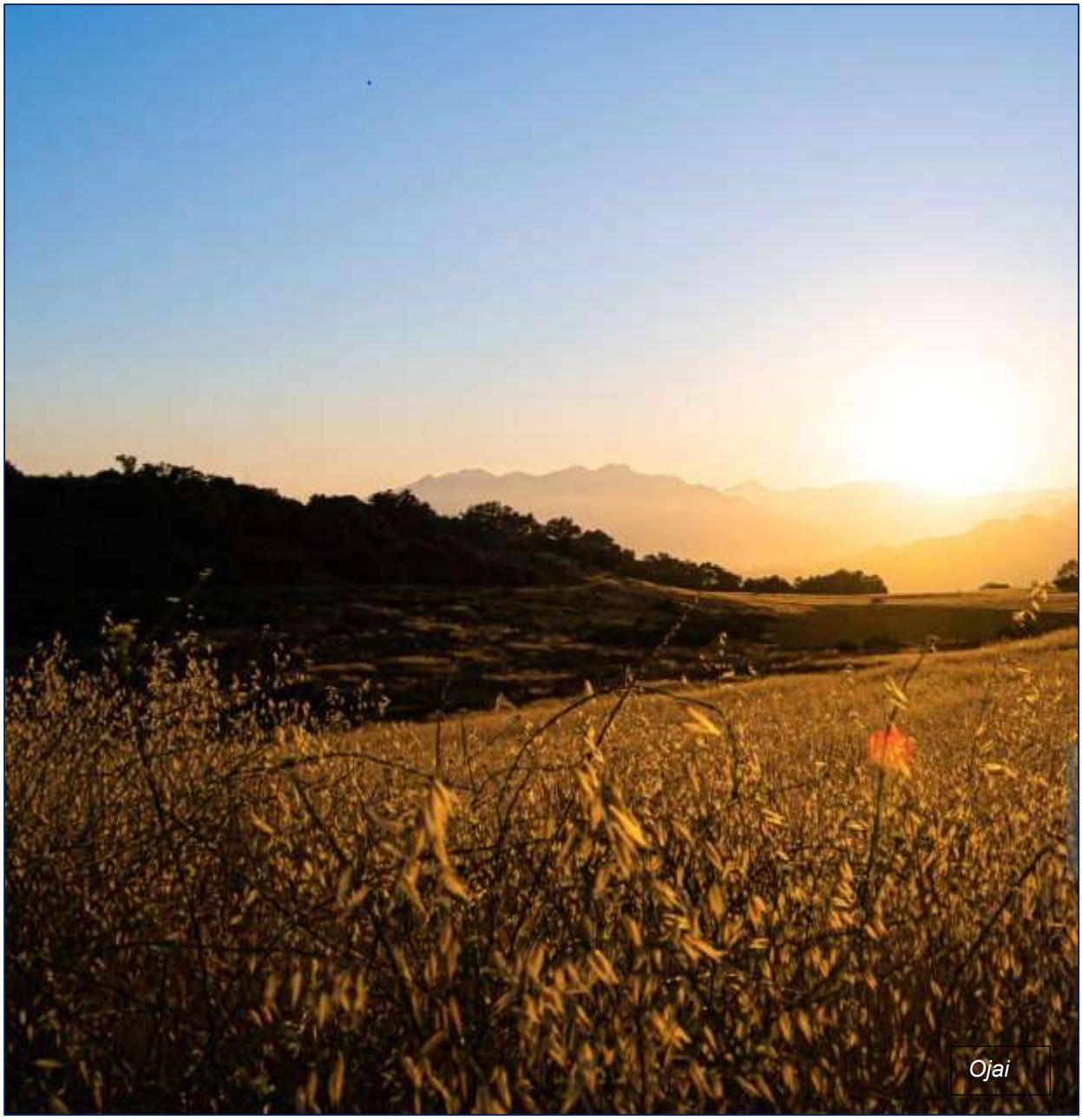
Executive Summary, County Description and MHSA Program



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How to read this report

Where does the Mental Health Services Act (MHSA) fit in with the Funding Ventura County Behavioral Health (VCBH) System of Care?

VCBH has several funding sources, of which the MHSA is one. The MHSA Plan does not represent all public behavioral health services in Ventura County, and it is not meant to function as a guide to all service options. Not all services can be funded under the MHSA. Reported funding can be from the County's local allocation amount or from state MHSA funding pot often in the form of grants. Funding can also be braided or leveraged with other monies such as Realignment or Medi-Cal dollars; those anticipated amounts are reported separately in the program expenditures plan section of this report and actuals are posted publicly in the Annual Revenue and Expenditures Report (ARER) found at www.vcbh.org[1].

What is the MHSA Three-year Program and Expenditure Plan?

It describes goals, objectives and interventions based on needs assessment, stakeholder feedback, and the possibilities and limits defined in State regulations. Every three years, Ventura County is required to develop a new Program and Expenditure Plan for the MHSA funding. The Three-year plan outlines and updates the programs and services to be funded by MHSA and allows for a new Three-year budget plan to be created. It also allows the County an opportunity to re-evaluate programs and analyze performance outcomes to ensure the services being funded by MHSA are effective. The current 3-year plan expires in June 2026. A single fiscal year begins July 1st and ends the following calendar year on June 30th. This year's report is year one of the Three-year plan.

What is an Annual Update?

MHSA regulations require counties to provide community stakeholders with an update to the MHSA Three-year plan, annually. The community planning process allows stakeholders the opportunity to provide feedback from their unique perspective about the programs and services being funded through MHSA. An annual update is a standalone report that conveys any changes to the current 3-year Plan. This year's Annual Update report focuses on year three of the current Three-year plan.

Understanding the numbers:

- Most of the data and the cost per client listed in the document refer to data and amounts from Fiscal Year 2023-2024. To write the plan, the most current and complete data and fiscal reporting (for a full 12 months) is from Fiscal Year 2023-2024.
- This document is written and adopted currently in the Fiscal Year 2024-2025 and will be articulated from that point in time and includes any changes taking place.
- This plan's title is reflective of the MHSA requirements and therefore will be named Ventura County's MHSA Annual Update for FY 2024- 2025.
- Funding for the MHSA is based on income tax and cannot be forecasted with complete certainty therefore all plans are subject to change and items that are outlined for funding in the current Three-year plan are updated in Annual Update Reports each subsequent year.

[1] https://assets-global.website-files.com/62e9972ac69f44f2d5f7aa52/65f09f130d3f078a60486039_DHCS_1822AJ_MHSA_Revenue_and_Expenditure_Report.pdf

BACKGROUND

Overview

In November of 2004, California voters passed Proposition 63, which created the Mental Health Services Act (MHSA). The Act instituted an additional 1% tax on any California resident with an income of more than $1 million per year, and annually, this tax is added to every dollar over $1 million residents earn. MHSA revenue is distributed to counties across the state to accomplish an enhanced system of care for mental health services, with a portion of the revenue distributed to agencies at the State level.

The passage of Proposition 63 provided the first opportunity in many years to expand County mental health programs for all populations, including children, transition-age youth, adults, older adults, families, and especially the unserved and underserved. It was also designed to provide a wide range of prevention, early intervention, and treatment services, including the necessary infrastructure, technology, and enhancement of the mental health workforce to effectively support the system.

As part of the system design, the Act provided five fundamental guiding principles in the MHSA regulations:

BACKGROUND

Community Program Planning (CPP) Summary

Pursuant to the Welfare and Institutions Code (WIC) Section 5848(a), the Mental Health Services Act (MHSA) requires an inclusive and ongoing Community Program Planning process to gather input regarding existing and forecasted community mental health needs, as well as an assessment of the current mental health system that gauges the overall impact and effectiveness of such programs. The results of this process inform future programming adjustments and determine whether additional or different services are required. In partnership with stakeholders, this process provides the structure necessary for the County to determine the best way to improve existing programs and utilize funds that may become available for MHSA components.

Programs Summary

The tables below reflect a summary of MHSA funded programming by component. Any updates or changes are noted in the corresponding column. Specific fiscal allocations per program for the Fiscal Year 2023-2024 are listed in the Program and Expenditure section of the report. Programs not yet launched are listed separately in the 3-Year plan update section below.

The tables below reflect a summary of MHSA funded programming by component. Any updates or changes are noted in the corresponding column. Specific fiscal allocations per program for the Fiscal Year 2023-2024 are listed in the Program and Expenditure section of the report. Programs not yet launched are listed separately in the 3-Year plan update section below.

Full Service Partnership (FSP)

Program	Changes	Fiscal Year		
		23-24	24-25	25-26
Youth FSP Program (ATLAS)		✓	✓	✓
Insights Youth FSP	Ended FY24-25	✓		
Transitional Age Youth (TAY) Expanded Transitions (TAY FSP)	Expanding	✓	✓	✓
Casa Esperanza TAY Transitions Program (TAY FSP)		✓	✓	✓
Assisted Outpatient Treatment (AOT) Program		✓	✓	✓
Adult Clinic Based FSP		✓	✓	✓
VCBH Adult FSP		✓	✓	✓
Empowering Partners through Integrative Community Services (EPICS)	Expanding	✓	✓	✓
VISTA	Expanding	✓	✓	✓
VCBH Older Adults FPS Program	Expanding	✓	✓	✓
Child Welfare FSP	New in FY25-26			✓
Youth Intensive Case Management FSP	New in FY25-26			✓

Outreach and Engagement (O & E)

Program	Changes	Fiscal Year		
		23-24	24-25	25-26
Rapid Integrated Support and Engagement (RISE)		✓	✓	✓

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BACKGROUND

Program Summary

General System Development (GSD)

Program	Changes	Fiscal Year 23-24	24-25	25-26
Administrative Infrastructure (temp staffing/consulting/facilities/clinic refresh)		✓	✓	✓
County-Wide Crisis Team (CT)		✓	✓	✓
Crisis Residential Treatment (CRT)		✓	✓	✓
Crisis Stabilization Unit (CSU) Children's		✓	✓	✓
East County Crisis Stabilization Unit	Delayed			✓
Eye Movement Desensitization and Reprocessing (EMDR)	New		✓	✓
Adult Short Term Treatment Team		✓	✓	✓
Youth and Family Intake Team		✓	✓	✓
Access Program (Access Line)		✓	✓	✓
Fillmore Community Project		✓	✓	✓
Transitional Age Youth (TAY) Outpatient Treatment Program		✓	✓	✓
VCBH Adult Outpatient Treatment Program		✓	✓	✓
The Client Network		✓	✓	✓
Family Access Support Team (FAST)		✓	✓	✓
Growing Works		✓	✓	✓
Mobile Response Team (MRT) for youth and families	Grant	✓	✓	✓
Forensic Pre-Admit		✓	✓	✓
Mental Health Diversion Grant Program		✓	✓	✓
Adult Wellness Recovery Center and Mobile Wellness		✓	✓	✓
TAY Wellness Center		✓	✓	✓
Client Transportation	Data included with outpatient services	✓	✓	✓
Language Services	Data included with outpatient services	✓	✓	✓
Peer Support Services	Expansion	✓	✓	
Wellness Everyday Website	New to CSS FY23-24	✓	✓	✓
Youth and Family Enhanced Care Management		✓	✓	✓
Semillas Planting Seeds of Wellness	New		✓	✓
Arts and Wellness Creativity though the Arts	New		✓	✓
Nates Place Wellness Center			✓	✓
Candella Peer Support and Workshops			✓	✓
Moorpark EPSDT Services			✓	✓
MESA Independent Living Support Services			✓	✓

Housing (HOU)

Program	Changes	Fiscal Year 23-24	24-25	25-26
RCFE (Residential Care for the Elderly)		✓	✓	✓
Board and Cares		✓	✓	✓
TAY D Street Housing		✓	✓	✓
Permanent Supportive Housing	Expansion	✓	✓	✓
Temporary Housing Vagabond			✓	✓
HHAP Grant	Grant		✓	✓
BH Bridge Housing Program Grant	Grant		✓	✓
Second Chance Housing Grant	Grant		✓	✓

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BACKGROUND

Program Summary

Prevention and Early Intervention (PEI)

Program	Changes	Fiscal Year		
		23-24	24-25	25-26
Multi-Tiered System of Supports, VCOE*		✓	✓	✓
Multi-Tiered System of Supports, LEA*		✓	✓	✓
One Step a La Vez Conocimiento		✓	✓	✓
One Step Early Intervention			✓	✓
Ignite Conocimiento		✓	✓	✓
Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) (VCAAA)		✓	✓	✓
Diversity Collective		✓	✓	✓
Project Esperanza	Expanding	✓	✓	✓
Tri-County GLAD	Adding EI Services	✓	✓	✓
Primary Care Integration with EDMR		✓	✓	✓
COMPASS		✓	✓	✓
Ventura County Power Over Prodromal Psychosis (VCPOP)		✓	✓	✓
Crisis Intervention Team		✓	✓	✓
Logrando Bienestar	Includes PYPF programing	✓	✓	✓
Rapid Integrated Support and Engagement		✓	✓	✓
Wellness Centers - Continued Expansion	Supporting MHSSA sites	✓	✓	✓
MHSSA Grant		✓	✓	
Healing the Community		✓	✓	✓
Bartenders as Gatekeepers		✓	✓	✓
Mental Health Awareness though the Arts	Late start		✓	✓
Girl Scouts Mental Health Wellness Badge			✓	✓
Wellness Centers at Community Colleges	New Program		✓	✓
Transportation Purchases			✓	✓
VC Family Justice Center Peer Program	New Program		✓	✓
Suicide Prevention Efforts and Events			✓	✓
Amplify Arts Project (Girls Rock SB)	Network Expansion	✓	✓	✓
Autism Society of Ventura County	Network Expansion	✓	✓	✓
Boys and Girls Club of Greater Oxnard & Port Hueneme	Network Expansion	✓	✓	✓
Childhood Matters	Network Expansion	✓	✓	✓
De Colores Multicultural Folk Arts. Inc.	Network Expansion	✓	✓	✓
Namba Performing Arts	Network Expansion	✓	✓	✓
No Limits Theater Group, Inc.	Network Expansion	✓	✓	✓
Nyeland Promise	Network Expansion	✓	✓	✓
Oxnard Performing Arts Center Corporation	Network Expansion	✓	✓	✓
Two Trees Community	Network Expansion	✓	✓	✓
VC Family Justice Center - Equestrian	Network Expansion	✓	✓	✓

Innovations (INN)

Program	Changes	Fiscal Year		
		23-24	24-25	25-26
Mobile Mental Health	Launching FY24-25	✓	✓	✓
Semi Statewide EHR Project		✓	✓	✓
Learning Collaborative Healthcare Network Early Psychosis Project (LCHN)	Launched	✓	✓	✓
Veteran Mentorship Program	Planned			✓
Collaborative Care Model	Planned			✓

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VENTURA COUNTY BEHAVIORAL HEALTH
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BACKGROUND

Program Summary

Workforce Education and Training (WET)

Program	Changes	Fiscal Year		
		23-24	24-25	25-26
Workforce Education and Training	Expanding	✓	✓	✓
Mentorship Internship Program (MIP)			✓	✓

Capital Facilities and Technological Needs (CTFN)

Program	Changes	Fiscal Year		
		23-24	24-25	25-26
Mental Health Rehabilitation Center (MHRC)			✓	✓
BCHIP Y&F Services Building (Braided Funding)		✓	✓	✓
East County Crisis Stabilization Unit (CSU)			✓	✓
Permanent Supportive Housing Units	Delayed			✓
Secondary Data System				✓
Psychiatric Health Facility (PHF)	New			✓

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BACKGROUND

Program Summary

The tables below reflect a summary of programming by component that were determined by the last community needs assessment, community planning processes, noted gaps in services according to existing and forecasted needs, and regulatory requirements. The full plan can be found on the VCBH website titled MHSA FYs 23-26 3-year plan. Changes from the 3-year plan are noted below.

Changes to the 3-Year Plan 2023-2026					
Updates	**23-24**	**24-25**	**25-26**	**Category**	**Changes**
Psychiatric Hospitalization Facility (PHF)			x	CFTN	Added back with potential of braided funding
Housing Vouchers/ Rental Subsidies			x	CSS	Changed to FY25-26
One Stop Site for Parents of SED Youth			x	CSS	Changed to FY25-26
Creativity though Music		x	x	CSS	Changed from INN dollars
Semillas		x	x	CSS	Changed from INN dollars
Family Justice Center - Peer Program Pilot		x	x	PEI	Changed from INN dollars
Clinic site expansion Y&F Division			x	CSS	Changed to FY25-26
COSRs (to maintain and create permanent supportive units)			x	CSS	Changed to FY25-26
East County Crisis Stabilization Unit (CSU)			x	CSS	Changed to FY25-26
Outreach and education improvements			x	CSS	Changed to FY25-26
Permanent Supportive Housing Units			x	CFTN/IT	Changed to FY25-26
Moorpark Y&F Program community O&E		x	x	CSS	Changed to CSS and name change
Clinic site expansion Adult Division			x	CSS	Changed to FY25-26
Board and Care Acquisition			x	CFTN/IT	Changed to FY25-26
Neurosequential Model Program				PEI	Name & category changed (line below)
Human Services Family Healing Initiative		x	x	CSS	Updated name & category
Temporary Housing		x	x	CSS	New Program
ECT treatment			x	CSS	New Service
VCOE Wellness Centers Continued Expansion			x	PEI	No expansion, additional money needed after the end of MHSSA
Community Innovation Projects				INN	Pursued with alternate funding
Co-Occurring support staff and programing for integrated care		x	x	CSS	Potential cost savings
Clinic Upgrades/Refresh		x	x	CSS	Previously under umbrella of Administrative Infrastructure Upgrades
Collaborative Care Model			x	INN	Pursuing Approval FY24-25
Mental Health Rehabilitation Center				CSS	Removed will exceed 3-year timeline

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BACKGROUND

Program Summary

Changes to the 3-Year Plan 2023-2026					
Updates	**23-24**	**24-25**	**25-26**	**Category**	**Changes**
Administrative Infrastructure Upgrades		x	x	All	Expanded projects to align with BHSA (site modifications)
Accounting System for Payment Reform			x	CFTN	Changed to FY25-26
FSP Expansion Youth Services			x	CSS	New programs
Medical Records Digitization		x	x	CSS	On Track to be spent at time of report
Addition of Staff (Treatment, Housing team, and Peers through the system)		x	x	CSS	
Crisis Tracking System		x	x	CSS	
Individualized Placement and Supported Employment (IPS)		x	x	CSS-FSP	
Medi-Cal Service Expansion for Early Intervention			x	PEI	
Mental Health Awareness through Arts		x	x	PEI	
Teen Drop-in Center Oxnard		x	x	PEI	
Transcranial magnetic stimulation (TMS)		x	x	CSS	
Transportation Purchases for Programs		x	x	CSS/PEI	
Therapy Dogs		x	x	CSS	
Wellness Centers at Community Colleges		x	x	PEI	

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BACKGROUND

Ventura County Behavioral Health (VCBH) Mental Health Block Grant Descriptions

Ventura County Behavioral Health (VCBH) Mental Health Block Grant Descriptions

The following block grant funding, a result of COVID-19 relief funding, has had an impact on several service areas. It has been listed here as a stand-alone and will be reported in greater detail in each of the following service areas throughout the report. In the Fiscal Year 2023-2024 MHSA money was utilized for these programs in addition to the grant money.

- GSD Crisis Stabilization
- GSD Peer Services

Community Mental Health Services Block Grant (MHBG)

In August of 2021, VCBH submitted grant applications to DHCS for the American Rescue Plan Act (ARPA). On February 16, 2022, the Department of Health Care Services (DHCS) awarded ARPA grant in the amount of $930,321, for the term of September 1, 2021, through June 30, 2025.

The supplemental funding for ARPA will be used by VCBH to support Crisis Stabilization Units (CSU) care coordination, develop an evidence-based Peer Support Program, and increase telehealth access to behavioral health treatment throughout the adult outpatient clinic system. Specifically, the CSU funding will be used by VCBH to recruit a bilingual Community Services Coordinator (CSC) to help facilitate Ventura County's crisis stabilization units, provide the appropriate level of care for CSU clients, and coordinate communication between the Ventura County crisis stabilization units, other mental health treatment providers, patients and their families/supports.

The Peer Support Program will utilize Peer Support Specialists to conduct outreach across all the Transitional Aged Youth (TAY) and adult community-based clinics with a specific focus on the Access Team, and Assist (VCBH's Assisted Outpatient Treatment FSP program) Peer Support Specialists will assist SPMI clients in: (1) navigating the treatment system, (2) attaining appropriate services, (3) connecting with community-based resources, and (4) developing the necessary coping skills to aid in alleviating the impacts of social stigma. All six positions had been hired in FY 23-24.

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BACKGROUND

Ventura County

Ventura County is situated along the Pacific Coast between Santa Barbara and Los Angeles Counties and consists of 1,843 square miles of land. It is set against undeveloped hills and flanked by free-flowing rivers. Ventura County is one of 58 counties in the State of California and offers 42 miles of beautiful coastline along its southern border, with the Los Padres National Forest making up the northern area. It has a beautiful, temperate climate, and its landmass rises from sea level to 8,847 feet at Mt. Pinos in the Los Padres National Forest. At certain times of the year, it is often possible to stand on the beach and see snow on the mountains.

Ventura County is made up of two major sections: East County and West County. Communities in the East County include Thousand Oaks, Newbury Park, Lake Sherwood, Hidden Valley, Santa Rosa Valley, Oak Park, Moorpark, and Simi Valley. West County consists of the communities of Camarillo, Somis, Oxnard, Point Mugu, Port Hueneme, Ventura, Ojai, Santa Paula, and Fillmore. The largest beach communities are in West County on the coastline of the Channel Islands Harbor.

Fertile farmland and valleys in the southern half of the County make Ventura County a leading agricultural producer. The Los Padres National Forest occupies half of the County's 1.2 million acres, and of the remaining land, nearly 60% is devoted to agriculture.

Ventura County has a strong economic base that includes major industries such as biotechnology, healthcare, education, agriculture, advanced technologies, oil production, military testing and development, and tourism.

Naval Base Ventura County is the largest employer with more than 16,000 employees, including civilians and military personnel. The Port of Hueneme is California's smallest and only deep-water port between Los Angeles and San Francisco and plays a major role in the local economy.

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BACKGROUND

Ventura County

Ventura County is home to two universities (California State University Channel Islands and California Lutheran University), several small private colleges, and three community colleges (Oxnard, Ventura, and Moorpark). Through these and other programs, Ventura County enjoys a strong structure for workforce development.

As of July 2023, the estimated population of Ventura County was 829,590.[1] Hispanic or Latinos comprised 44.8% of the population and non-Hispanic/Latino comprised 55.2%. Approximately 21.5% of the population was under 18 years of age while 18.1% of County residents were 65 or older. Ventura County was also comprised of 22.9% foreign-born people and 4.9% veterans.

The median household income was $107,327, however, 9.8% of the people in the County were below the poverty level.

The chart below reflects additional Ventura County Census demographics.

Ventura County Census[1] Population	**N=829,590**
Census Age Groups[2]	
0-17 yrs.	21.5%
18-24 yrs.	8.7%
25-64 yrs.	51.7%
65 and older	18.0%
Gender	
Female	50.3%
Male	49.7%
Other gender identity[2]	0.5%
Veteran Status	
Veteran (among 18+)	4.9%

Underserved Populations	
Latinx	African American
LGBTQ+	Unhoused
Risk of Suicide	
Those with co-occurring disorders (mental disorder and substance use disorder)	

Race/Ethnicity[3]	
American Indian/Alaskan Native (alone)	1.4%
Asian (alone)	7.3%
Black/African American (alone)	2.0%
Hispanic or Latino (any)	44.8%
Native Hawaiian/Pacific Islander (alone)	0.2%
White (not Hispanic/Latino)	41.4%
White (all)	75.8%
Multi-racial	25.3%
Another Race (alone)	12.6%
Hispanic or Latino (any)	44.8%
Non-Hispanic	55.2%
Language Spoken	
English (only)	60.5%
Spanish (any)	31.6%
Other	7.9%
Language thresholds are English and Spanish.	

[1] From the 2023 US Census Bureau American Community Survey 1-year estimates unless noted otherwise.

[2] The source reports 0.5% of individuals aged 18+ in the state of California identifies as transgender. https://williamsinstitute.law.ucla.edu/publications/ /trans-adults -united-states/

[3] Race/Ethnicity: More than one option is permitted.

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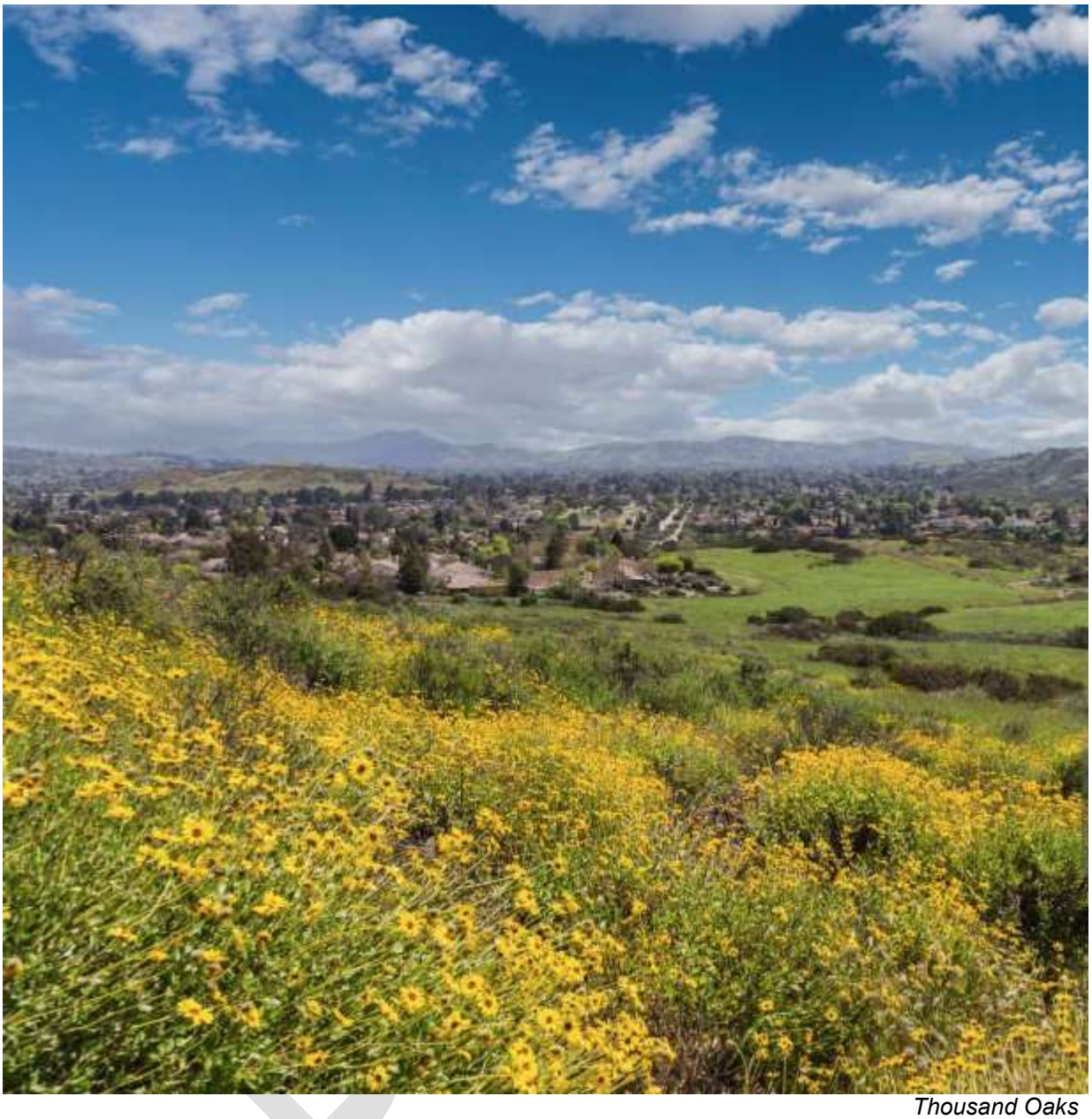

Thousand Oaks

COMMUNITY PROGRAM PLANNING (CPP)

In partnership with stakeholders, the CPP process provides the structure necessary for the County to determine the best way to improve existing programs and utilize funds that may become available for the MHSA components.

There are numerous groups of stakeholders involved in the CPP process and ongoing feedback is received from the various groups such as, the Behavioral Health Advisory Board (BHAB) members, community providers, focus groups and general community meetings. Additionally, this process is designed to hold annual public education and to provide input on goals set by Ventura County Behavioral Health (VCBH), the Mental Health Oversight and Accountability Commission (MHSOAC), and BHAB, including any community gaps identified by the triannual needs assessment, these same entities, and/or community stakeholders. As of January 1, 2026, the MHSOAC updated its name to the Behavioral Health Oversight and Accountability Commission also known as the Commission for Behavioral Health.

Community/stakeholder feedback is essential to developing or enhancing behavioral health programs/interventions. This includes the designated MHSA team member's review of annual outcomes and previous-year comparisons, contractual obligations, and cost-effectiveness of all currently funded MHSA programs, which are made available to the community through the MHSA Annual Updates and 3-year plans. Based on the community planning process feedback, recommendations are presented to the VCBH Director followed by presentations to the BHAB as allowed.

Additional CPP processes may take place for specific standalone programs, projects, or initiatives if funding and timeliness allows.

Overview of the Community Planning Process for the Annual Update

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COMMUNITY PROGRAM PLANNING (CPP)

The following table illustrates the demographics of those who provided feedback in the County CPPP surveys versus the Census for Ventura County, and their difference.

	CPPP Participants (N=44)	VC Census[1]	Difference
Requested Age Breakouts [2]	(n=38)	(N=829,590)	
0-15 yrs.	0.0%	NA	NA
16-25 yrs.	0.0%	NA	NA
26-59 yrs.	76.3%	NA	NA
60 and older	23.7%	NA	NA
Census Age Breakouts [2]			
0-14 yrs.	NA	17.3%	NA
15-24 yrs.	NA	12.8%	NA
25-59 yrs.	NA	45.4%	NA
60+ and older	NA	24.3%	NA
Race/Ethnicity	(n=41)		
American Indian or Alaskan Native	0.0%	1.4%	-1.4%
Asian	9.8%	7.3%	2.5%
Black or African American	4.9%	2.0%	2.9%
Hispanic or Latino	70.7%	44.8%	25.9%
Native Hawaiian or Pacific Islander	0.0%	0.2%	-0.2%
White (alone)	17.1%	41.4%	-24.3%
White (not alone)	2.4%	75.8%	-73.4%
Multi-racial	0.0%	25.3%	-25.3%
Another Race/Ethnicity	0.0%	12.6%	-12.6%
Gender	(n=41)		
Female	85.4%	50.3%	35.1%
Male	12.2%	49.7%	-37.5%
Other gender identity	2.4%	0.5%[3]	1.9%
Veteran Status	(n=39)		
Veteran (among 18+)	5.1%	4.9%	0.2%
Have a Disability	(n=36)		
	25.0%	12%	13.0%
LGBTQ+[4]	(n=36)		
	19.4%	5.3%	14.1%
Language Spoken at home	(n=41)		
English	65.9%	60.5%	5.4%
Spanish	51.2%	31.6%	19.6%
Another Language	0.0%	7.9%	-7.9%
Health Insurance Status[5]	(n=34)		
No insurance	11.8%	7.2%	4.6%
Private insurance	32.4%	66.2%	-33.8%
Public insurance	47.1%	38.2%	8.9%

[1]From the American Community Survey for Ventura County, 2023 1-year estimates unless noted otherwise.
[2]Requested CPP age breakouts did not match Census age breakouts.
[3]Gender: The source below reports 0.5% of individuals aged 18+ in the state of California identify as transgender
Source: https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/
[4]Sexual Orientation: The American Community Survey only reports two genders (male and female) and does not ask about sexual orientation. The Gallup Daily tracking survey reports 5.3% of California's population (from 2012-2017) answer yes to "Do you, personally, identify as lesbian, gay, bisexual, or transgender?"
Source: https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT#density
[5]Health Insurance Status: Percentages add to over 100% due to census estimates reflecting individuals with multiple coverages.

COMMUNITY PROGRAM PLANNING (CPP)

Stakeholder Involvement

The Mental Health Services Act (MHSA) requires public involvement in the stakeholder process because it is crucial in achieving an equitable 3-year program plan and annual updates. Groups involved in the CPP process include consumers, law enforcement, advocacy groups, and partner agencies. While there are shared requirements for CPP, the process allows Ventura County to tailor its programming to align with its specific needs and adhere to State priorities and regulatory requirements. Ventura County's Stakeholder policy can be found in the Appendix H of this report.

The basis for the Ventura County planning process is found in WIC 5898, 5813.5d and 5892c. In Ventura County, standing groups represent different interests across the County, and as the need arises, focus groups are created to address the needs of these populations.

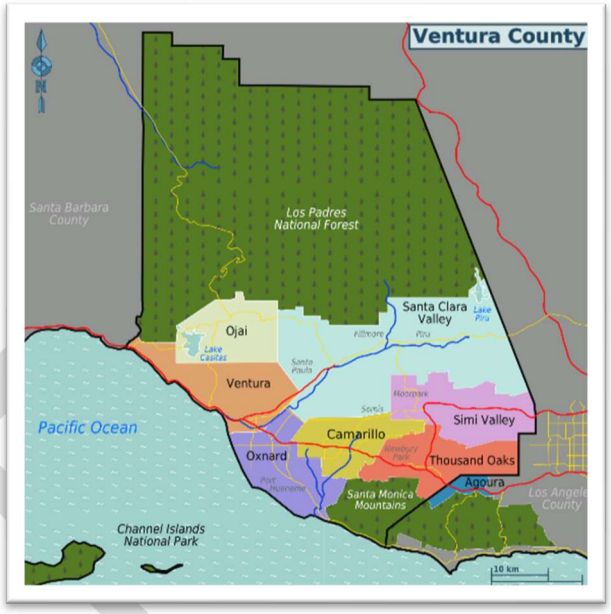
In addition to availing opportunities to participate within these forums, a formal, robust Community Health Needs Assessment (CHNA) was conducted across the County in accordance with the commitment of Ventura County Behavioral Health (VCBH) to address the health needs of a diverse population. An additional targeted component of the CHNA was also conducted, focused solely on unserved and underserved populations. Stakeholder involvement was accomplished by using different forums, which include various stakeholder groups listed below:

COMMUNITY PROGRAM PLANNING (CPP)

Behavioral Health Advisory Board (BHAB)

The mission of the BHAB is to advocate for members of the community that live with mental illness and/or substance abuse disorders and their families. This is accomplished through support, review and evaluation of treatment services provided and/or coordinated through the VCBH.

The BHAB is made up of stakeholders appointed by the Board of Supervisors. It serves in an advisory capacity to VCBH Director and the Board of Supervisors. It plays a significant role in facilitating public discussion of the Mental Health Services Act (MHSA) plans and updates, provides feedback and conducts the public hearing. The BHAB, as the local mental health board, has authority to submit plans and updates to the Board of Supervisors for final approval. The BHAB is made up of 20% consumers and 20% family members and includes law enforcement, veterans, and a psychiatrist. All geographic regions are represented. The table below lists the current membership and their geographic representation, and with term dates.



Ventura County Behavioral Health Advisory Board

Supervisor, Matt LaVere

Membership Roster for Fiscal Year 2023-2024

District 1	Claudia Armann 03/11/21 to 03/10/24	District 2	Carol J. "C.J" Keavney 01/08/22 to 01/07/25
	Kevin Clerici 10/07/21 to 10/06/24		Diane McKay 09/17/22 to 09/16/25
	Genevieve Flores-Haro 04/27/21 to 04/26/24		Elizabeth R. Stone 03/01/22 to 02/28/25
	Cheryl Heitmann 05/11/21 to 05/10/24		Vacancy
District 3	Nancy Borchard 01/26/21 to 01/26/24	District 4	Jennifer Morrison 02/09/21 to 02/09/24
	Janis Gardner 04/24/21 to 04/24/24		Dalia Robkin 04/25/23 to 04/24/26
	Naomi (Nomi) Marrufo 09/13/22 to 12/01/23		Christopher Tejeda 09/18/21 to 09/17/24
	Vacancy		Vacancy
District 5	Soledad Barragán 09/16/23 to 09/15/26		Law Enforcement Rep. Sergeant Shawn Pewsey 03/28/23 to 03/27/26
	Michael Rodriguez 01/25/23 to 01/24/26		Veteran Rep James Espinoza 10/14/21 – 10/13/24
	Marlen Torres 01/25/23 to 01/24/26		
	Liz Warren, MHRP 04/27/22 to 03/22/24		

COMMUNITY PROGRAM PLANNING (CPP)

Workgroups

Ventura County Behavioral Health conducts active outreach to ensure key stakeholders are included in the development of programs and services, so they are reflective of the needs of the population to be served. During the planning period, targeted groups included underserved geographic areas, threshold languages, unhoused individuals, and clients of VCBH services

Informing the Community about the CPPP Sessions

A media plan is generated for any CPP process and the corresponding events. Announcements are made at the BHAB and other County committee meetings as well as flyer distribution at clinics and community partners and providers. The media plans include a mixed media approach with advertisements on social media and the department's websites WellnessEveryday.org and vcbh.org as well as traditional print media such as local newspapers.

The promotional efforts resulted in a total of 1,531,776 impressions.

- Print & Digital: 1,079,586
- Social media: 452,190

An example of the advertisement is listed below to ensure the community was made aware of the events:

Print and Digital Media		Social media	Run Dates
• Amigos 805 • Santa Paula Times • Fillmore Gazette • Vida • Ventura County Star • Acorn	• VC Reporter • Ojai Valley News • El Latino • The Breeze	• Facebook • Instagram	01/17/2025 to 02/19/2025

Consumer and Family Groups

Feedback is encouraged by other stakeholder groups, such as United Parents, NAMI, and the Client Network through direct consumer/family contact and by encouraging their participation in the BHAB as well as subcommittees, workgroups, and task forces. Another avenue for engagement is through VCBH's Patients Rights' Advocate, whose function is to provide information and investigate concerns.

Issue Resolution Process (RP)

Consumers may also voice their views/concerns through the issue grievance process (please see policy procedure in Appendix I). At the time of this report, 78 grievances have been filed regarding services that are funded by the MHSA for Fiscal Year 2023-2024.

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UPDATE ON THE COMMUNITY MENTAL HEALTH NEEDS ASSESSMENT (CMHNA)

Community Planning Process for the Annual Update

Community Planning meetings take place annually. Planning for an Annual Update report focuses on communicating changes to the current 3-year plan and receiving feedback on proposed changes. However, because of the unprecedented amount of money received during the annual adjustment in the summer of 2023, VCBH has also used the CPPP events to request new proposals and ideas for MHSA funding.

Feedback Type	2024 Dates	Locations	Total
In person events	February 11th February 13th February 27th	Fillmore Ventura Santa Paula	50
Virtual Event	February 18th	Online	29
Response Surveys	Received from Feb 11th through March 30th 2025	All in person events and online attendees	44
		Total	**123**

Four events were held in East and West County. Three events took place in person and one via Zoom. All events offered Spanish translation the threshold language in the County. Handouts and PowerPoint slides were provided in English and Spanish. Childcare and refreshments were also supplied. At these meetings, the VCBH team presented proposed changes to the 3-year plan and upcoming legislative changes were discussed. Copies of PowerPoint and subsequent materials can be found in the appendix of this report.

Feedback from the Community Program Planning Process can take place during a meeting, through surveys, or via email up to 30 days after the meetings took place. As feedback is received, the program plan is adjusted when feasible. Below is an overview of the feedback and sentiments that were received. Participant demographics have been added to the CPP participation table listed on page 18.

The following feedback was provided during in-person meetings.

Verbal Feedback

- Question Now that the State will be making more decisions re: MHSA/BHSA funding, how can the community notify the State we want to be included in local planning decisions?
    - Response: Staff reiterated CDPH will provide funds to the local public health department. Community members can email CDPH, participate on public listening sessions, and review/comment on documents on the BHSA website, and they can include comments on the CPPP surveys passed out tonight. The CPPP survey responses will go into our report. This report is submitted to the Ventura County Board of Supervisors.
- Question: I know of only one inpatient SUS facility in Ventura County, and it has a long waiting list. How do we get more treatment facilities?
    - Response: Explained the efforts it made to get women's facility and let them know department is working towards more.
- Question: Attendee stated she has lived experience, and said it is very difficult for individuals on Medi-Cal to get SUS related treatment; asked if Medi-Cal would cover the cost for in-patient stays at new facilities.
    - Response: Explained VCBH's target population is individuals with Medi-Cal and it will continue with BHSA implementation.
- Question: Can VCBH help with conservatorship? The laws are complex regarding conservatorship and recently changed to include mental health and SUS issues.
    - Response: Explained this is a legal process, folks can get free legal assistance at the courthouse, and we have staff that can help explain the various steps.

- Question: What will happen with the Wellness Centers at the schools given the funding changes?
    - Response: Explained the department is trying to offer support though the end of the MHSA and other state funding may be available including billing for wellness coaches in the schools.

- Question: If someone is experiencing Domestic Violence, where should they seek assistance?
    - Response: Explained it can depend on the situation and needs of the individual. VCBH partners with 211 to link help seekers to services based on their needs. VCBH's community access line can also assist.

- Question: Santa Paula, Piru, and Fillmore are disadvantaged communities; accessibility in these rural areas is hard. Will the new funding be distributed due to great need or divided up in another way?

    - Response: Explained, the department is still figuring that out. Some services have to be funded as they are mandated by law, for example locked facilities for high intensity, 24/hr. care etc. Once we have the mandated services established then we move on to the additional community needs. We are starting here, listening to the community. We will then look at programs that are working and how to keep them or expand them. Attendees encouraged folks to reach out to local elected officials, such as city council members to communicate concerns, re: gaps in mental health services in the community.

    - Response: Explained the Ventura County Community Health Improvement Collaborative (VCCHIC) is currently administering the 2025 Community Survey to hear from community members what is needed to help improve health and wellbeing across Ventura County. Encouraged attendees to fill out paper surveys, use the QR code to take the survey online (attendees were shown how to use a QR code) and ask friends and family members to fill out the survey to let the VCCHIC know what the priorities are for the Santa Clara Valley area. Attendees were reminded that the survey is taken anonymously. Survey respondents can assist loved ones take the survey too. E.g., take the survey themselves and then complete the survey on behalf of their minor child (i.e. family members can have different health insurance and be in different systems of care with different needs).

    - Attendees were also encouraged again to take the CPPP Survey for VCBH, available in hard copy or via QR code. The CPPP survey will help prioritize mental health needs over the next year until the BHSA is implemented fully. Individuals can also email in their comments to MHSA@ventura.org.

- Question: Can you provide some examples of what prevention services are? Do they include wellness centers and the TAY tunnel?

    - Explained that the current location of the CPP event tonight is a prevention program and the school wellness centers are PEI funded but the TAY Tunnel and the Adult Wellness centers are focused on clients and funded out of the CSS bucket. Prevention programs are mostly community based and focused on interventions that help to screen and identify individuals at risk of mental health issues.

- Question: Will hotels be turned into housing like Vagabond?

    - Response: Yes, the Vagabond hotel has been turned into transitional housing. If other opportunities come up, we can use BHSA money to expand.

- Question: When you say "housing support" will this include case management?

    - Explained that would mostly be funded out of the Behavioral Health Services and Support bucket.

- Question: Will the PHF be locked or an unlocked facility?

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  - Explained yes this will be locked in the sense that some individuals would be there on a hold however others would be voluntary thus, it is also unlocked.

- Question: Could you provide an example of dual diagnosis?
  - Response: Explained that dual diagnosis can include substance use disorders along with another mental health diagnosis.
- Question: Once you have certification for medical billing, who do you reach out to?
  - Response: It was explained you need to communicate with your contract liaison to connect you with the appropriate individual for the next steps.
- Question: With innovation funding, is that still open? If we wanted to submit a program idea?
  - Explained that innovation funding is no longer a specific allocation under the BHSA so we will not be soliciting new applications. Another way to apply for funding is thought the county's contract site or partner with existing organizations.
- Comment: There needs to be additional programs that focus on the Hispanic homeless population.
- Question: How long do you think Proposition 1 will last?
  - Explained that this will continue unless there is something else that will replace it, like it did with MHSA.
- Question: How are you getting the information for the CHNA (Community Health Needs Assessment) survey out to the community?
  - Explained that it's a collaboration between VCBH, VCPH, and other healthcare organizations. Everyone is sending it out and advertising. VCBH has funded newspaper ads, posts on social media accounts, as well as paper distribution.
- Community member suggested a 45 second video explaining what CHNA is and how to complete it.
- Comment: Community members assume BHSA will be like when MHSA first began and caused some confusion.
- Comment: One-time funding being received was $31M.
- Comment: Could we have a copy of the Excel list. Are we still on track for the RCFE? (MHRC is on track.) A: Infrastructure project not funded by MHSA dollars. Not coming out of CFTN.
- Comment: What are the FSP programs? For expansion?
  - Response: VCBH has 8 FSP programs. We are adding Child welfare system.
- Question: Are there faith-based coalitions with VCBH and African Americans currently?
  - Response: Yes, there are faith-based partnerships, but not in the African American community.
- Question: Accessing services for ages 0-5? Oakview/Ojai?
  - Response: All of our children's services have services for youth 0-5. Also currently have an RFP open for services 0-5 offered, don't know if anyone applied or they are in those areas.

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- Question: Do we have resources in the County for events like this (referenced a person with Autism who was having a crisis)?
    - A: This has been identified as an ongoing challenge, VCBH and the Regional Center recently revamped their MOU to better coordinate for clients. The Crisis Stabilization Units are available for youth and adults. These services are designed to be a support for people in a crisis for up to 23 hours.
- Comment: If we don't have housing wrap-around services, it will be unsuccessful. (The department) should focus on utilization of Peer Support Specialists and FSP really doing what they need to be doing.
- Comment: Recommendation planning for priority communities affected by Prop 1 prior to presentations.
- Comment: Thoughts: It is exciting to see that we will be having more facilities so that family members in our community will not have to drive as far to connect. As we know that is part of the Mental Health journey.
- Question: For the expansion of early intervention services is there an estimate for services with a focus on serving children 0-5? I work in a capacity where I support that age group and their families with accessing services and have found very few in our county that accept Medi-Cal that have openings. Are we also looking at creating more opportunities in Oakview/Ojai area?
- Chat: We also work with VCOE SELPA and Prevention departments.
- Question: Is it correct to characterize these (housing programs under BHSA) individuals as FSP?
    - No, not all these programs would be FSP level of care. That is a change that comes with the BHSA.
- Question: Is the grant funding being spent this year?
    - This process (CPP) is the update on how we are spending that money, what has happened and what will happen and what's changed.
- Question: Will that make ECT more available?
    - Re: bringing ECT in-house versus paying out of house on a case-by-case basis.
- Question/Comment: I am trying to get an idea to relay how many programs exist that emphasize aid for older adults or a senior center. I read an article on a finding of 2022 healthcare assessment that pointed out Alzheimer's as a leading cause of death after cancer and heart disease. Based on this there doesn't seem to be enough emphasis on Alzheimer's care or treatment. Who is the main provider of care? I think it is interesting since it is a mental health issue. With the new money for housing, that could help in that regard.
- Comment: I think this is too slow; Ventura County was one of the counties that was behind in implementation for the mental health for all websites so, just too slow on progress and developing. We should be leaders.
    - Response: We are following the timeline set by the state so it's not a local process but thank you for making us aware we will have to look into that report page.
- Comment**:** It is exciting to see that we will be having more facilities so that family members in our community will not have to drive as far to connect. As we know that is part of the Mental Health journey.
- Several participants expressed concern that some community programs might be eliminated due to new regulations.

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Update on the Community Mental Health Needs Assessment (CMHNA)

Community Planning Process for the Annual Update

Written Survey Feedback

Agree or Strongly Agree (N=42-44)

I am satisfied with the presentation I attended	98%
The presenter(s) provided important information	98%
The presenters were engaging	93%
I am happy with the amount of information presented in today's session	91%
I was satisfied with the variety of topics presented	91%
The event provided me with valuable information	98%
There was enough time for discussion	95%

Of the 44 completed surveys, 26 respondents provided written feedback on the following open-ended response questions:

1. Based on the Proposition 1 information you received, do you have any additional questions or concerns?
2. Do you have any other feedback?

Their comments were categorized into the four themes described below.

General Session Feedback

Many respondents appreciated the clear and accessible presentation of information, as well as the County's ongoing support of the community. To enhance future presentations, they suggested including a key for acronyms and providing materials in advance to allow for better comprehension. Additionally, respondents recommended a follow-up listening session to further discuss questions and concerns. There was also strong interest in staying engaged and receiving updates on Prop 1.

Priority Populations

Respondents identified various populations within their communities that they believe need greater support and services, including older adults, youth experiencing mental health and substance use challenges, individuals with special needs, and marginalized groups such as the LGBTQ+ community.

Prop 1 Implementation

Questions and concerns regarding the implementation of Prop 1 raised by respondents spanned the following areas:

1. Location and Approval of Housing
2. Availability and Access to Housing
3. Impact on Homelessness
4. Inclusion of Case Management and Supportive Services
5. Demographics and Equity in Housing Allocation

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Update on the Community Mental Health Needs Assessment (CMHNA)

Community Planning Process for the Annual Update

Access to Services

Several respondents emphasized the challenges of accessing services within the County. Key issues included a desire for more treatment facilities, greater communication and education about services, and decreased waiting times.

County Response to Survey Feedback

Community members consistently focused on concerns regarding loss of services for underserved populations, access to services, and many questions about the expanded housing requirements. The County shares the community's questions and concerns regarding the required changes for BHSA. A variety of potential plans are being considered though the Prop 1 planning process. The planning process will include a round of meetings in the fall of 2025 to share community need assessment findings and solicit solutions. Another round of meetings will take place in the Spring outlining the full plan for the transition from MHSA to BHSA and all additional funding streams vis the Integrated Plan.

All of the CPPP meeting schedules will be shared publicly via the MHSA listserv and at the BHAB monthly meetings. To be added to the MHSA listserv, community members may email MHSA@ventura.org. The websites VCBH.org and Wellness Everyday.org are also kept up to date with all public meetings.

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Update on the Community Mental Health Needs Assessment (CMHNA)

Update on the 3-year plan

Results of the extended CPP process and community health needs assessment completed in Fiscal Year 2021-2022 resulted in a set of prioritization areas for the current 3-year plan Fiscal Year 2023-2026. The results are the five categories listed here in alphabetical order and which the department plans to leverage existing operations and utilize local MHSA funding to implement. MHSA funding is not a guaranteed amount. As such, updates on this list will be dependent on allocation amounts and will be communicated through subsequent Annual Updates and Program Review Summary tables (located in section two of this report). Regardless of funding these priorities will be the guide for the full three years of the plan.

Priorities for the Fiscal Year 2023-2026 3-Year MHSA plan

- **Access**
  a. Improved articulation of continuum of care and drivers of levels of care
  b. Examine timeliness in relation to the level of care.
  c. Examine quality improvement opportunities around physical locations and remote access.
  d. Develop options for immediate response for enrolled youth.

- **Alternatives to VCBH**
  a. Develop more contracted clinical providers/options for early intervention services.
  b. Develop more non-clinical providers/options through mini grants (e.g., drop-in centers, after school programs, indigenous/culturally informed interventions, etc.)
  c. Develop session based indicated BH prevention interventions for high schools.
  d. Develop more providers/options for those with other conditions (e.g., developmental/intellectual, traumatic brain injury, dementia, etc.)

- **Clinical Treatment & Services**
  a. Addition of staff clinic/program
  b. Expand the number/nature of physical plants to provide clinical treatment and services.
  c. Add/expand the types of treatment, cultural and indigenous practices, and other services provided by VCBH (possibly involves the purchase of equipment and supplies) Some examples include expanding the role of peers and increasing 24/7 community crisis response services.

- **Housing**
  a. Addition of staff for the development of a specialized housing team.
  b. Acquisition/development/preservation of housing.
  c. Financial support to preserve/expand existing tenancy for VCBH clients.

- **Outreach & Education**
  a. Increase outreach capacity for vulnerable and at-risk populations (i.e., in-house and via contractors)
  b. Expand media campaigns to target vulnerable populations at all care levels.
  c. Expand staff and provider training menu.
  d. Expand specialized Behavioral Health Outreach Team to:

     1. Educate around moderate-severe (VCBH domain) versus mild-moderate (others) mental illness; and significant functional impairment (i.e., what VCBH can be expected to do).
     2. Educate around stigma reduction, substance use and impacts, trauma, diversity, equity and inclusion, changes across the lifespan, and other pertinent topics.

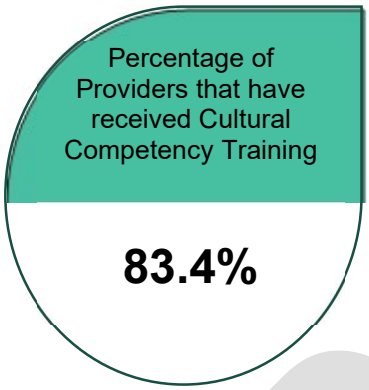
Update on the Community Mental Health Needs Assessment (CMHNA)

Program Planning Process and Network Adequacy Certification Assessment (NACT)

Network Adequacy assessment is submitted annually to assess the VCBH provider system. As of July 2021, services such as Mental Health Services, Case Management, Crisis Intervention, Medication Support, Intensive Care Coordination, Intensive Home-Based and Field support were provided by 645 providers.

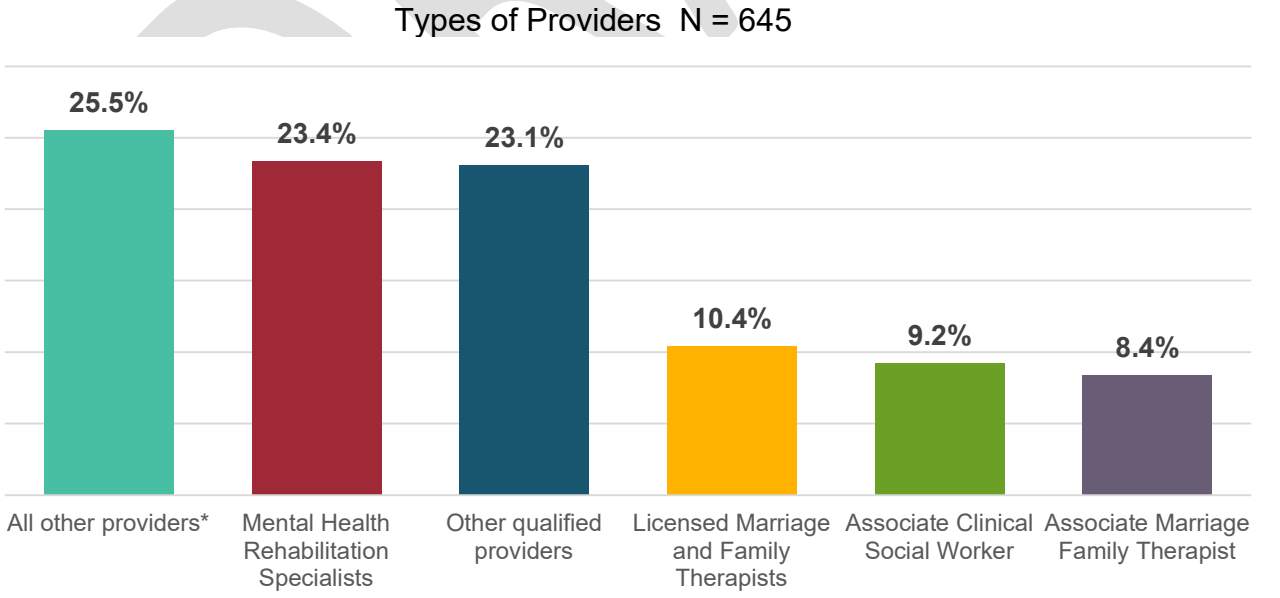
Provider Information (according to NACT, November 2024)

Through this assessment VCBH can assess how many of the existing staff are able to provide culturally competent services, in which languages and whether the Workforce Education Training plan should be adjusted accordingly. Additional details on this plan can be found in the WET section of this Annual Report.

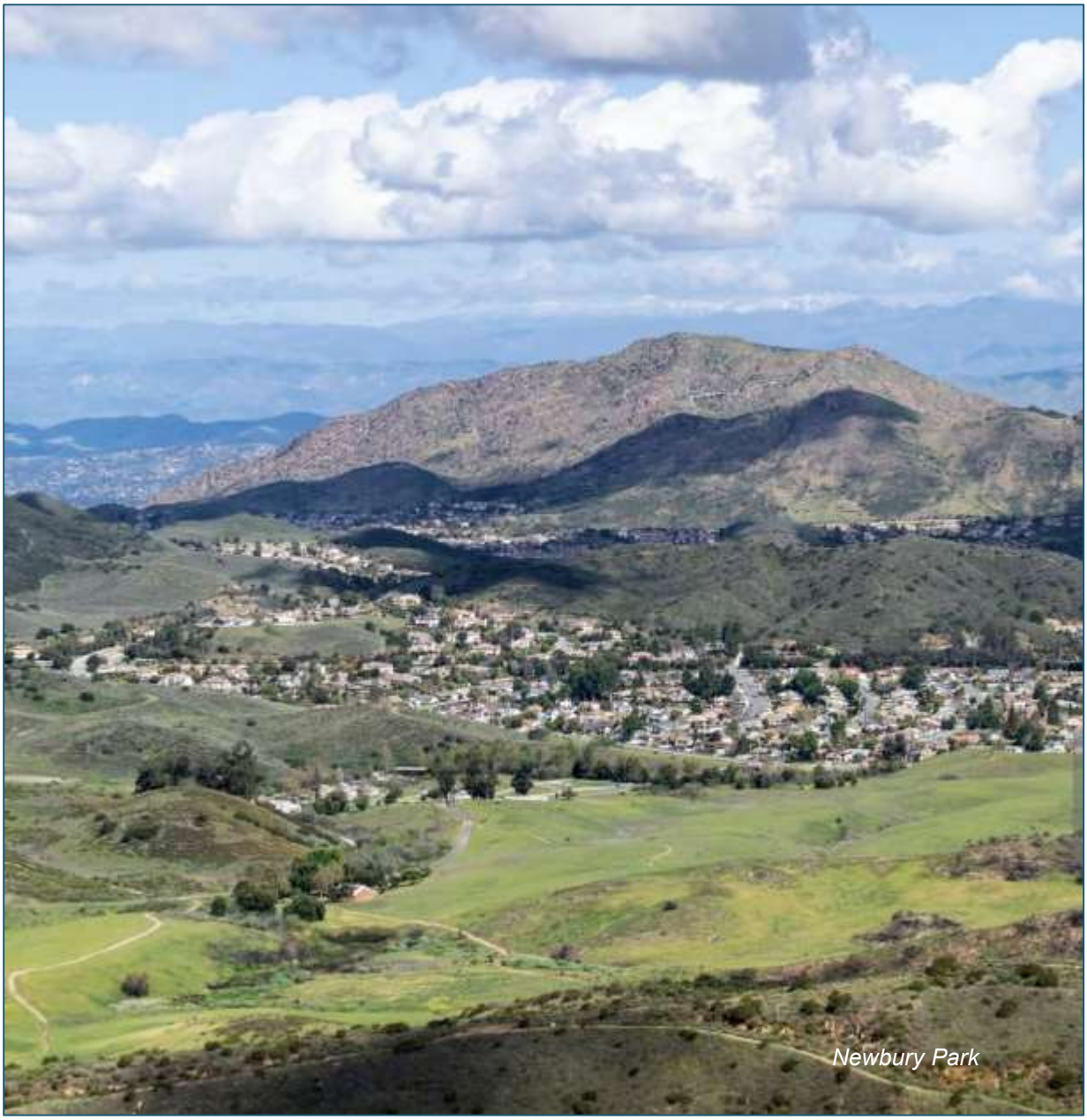


Languages other than English spoken by Ventura County providers*	% of providers that speak this language*
Arabic	0.2%
Armenian	0.5%
ASL	0.5%
Cantonese	0.2%
Farsi	0.8%
Mandarin	0.3%
Russian	0.5%
Spanish	26.2%
Tagalog	0.9%

*Some providers speak more than one language other than English



* Associate Professional Clinical Counselors, Licensed Clinical Social Workers, Licensed Physicians, Licensed Professional Clinical Counselors, Licensed Psychiatrists, Licensed Psychologists, Licensed Vocational Nurses, Nurse Practitioners, Psychiatric Technicians, Registered Nurses and Waivered Psychologists


Newbury Park

COMMUNITY SERVICES AND SUPPORTS (CSS)

Introduction

Community Services and Supports (CSS) is the largest component of the Mental Health Services Act (MHSA). It focuses on community collaboration, cultural competence, client- and family-driven services and systems, wellness (which includes concepts of recovery and resilience), and integrated service experiences for clients and families, as well as serving the unserved and underserved. Housing is also a large part of the CSS component and will continue to grow in the coming years. The County system of care under this component consists of programs, services, and strategies identified by the County through the stakeholder process to serve unserved and underserved populations with serious mental illness and serious emotional disturbance, while emphasizing a reduction in service disparities unique to the County.

Programs funded by this component are presented in this report in accordance with the following regulatory categories:

- Full Service Partnership (FSP)
- Outreach and Engagement (O&E)
- General System Development (GSD)
- Housing

Program Demographics - Unduplicated Clients

Age Group	n = 13,370
0 - 15 yrs.	1,483
16 - 25 yrs.	2,564
26 - 59 yrs.	7,181
60 & older	2,142
Gender Identity	**n = 13,370**
Female	6,028
Male	5,171
Transgender	17
Transgender woman	18
Transgender man	18
Non-Binary	9
Other	9
Unknown/Not Asked	267
Unknown / Not Reported	1,833
Race	**n = 13,370**
White	4,692
African American or Black	335
Asian	187
Native Hawaiian or Other Pacific Islander	24
Alaska Native or Native American	79
Other	4,137
More Than One Race	5
Unknown / Not Reported	3,911
Ethnicity	**n = 13,370**
Hispanic	4,977
Non-Hispanic	4,184
More Than One Ethnicity	2
Unknown / Not Reported	4,207
Veteran Status	**n = 13,370**
Yes	5
No	997
Unknown / Not Reported	12,368

Sexual Orientation	n = 13,370
Bisexual	53
Declined to state	23
Gay (male)	7
Heterosexual / Straight	1,150
Lesbian (female)	7
Prefer not to answer	13
Transgender	13
Unknown/Not Asked	12,099
Unsure / Questioning	5
Language Spoken	**n = 13,370**
American Sign Language (ASL)	16
Arabic	7
Cambodian	1
Cantonese	2
English	9,881
Farsi	7
French	1
Japanese	1
Korean	1
Lao	1
Mixteco	2
Other non-English	22
Portuguese	1
Russian	5
Spanish	1,324
Tagalog	8
Thai	3
Unknown / Not Reported	2,073
Vietnamese	14
Disability - Not Collected	

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

COMMUNITY SERVICES AND SUPPORTS (CSS)

Fiscal Year 2023-2024 CSS Programs Table

The following table lists all CSS programs and serves as a crosswalk to the program names in the submitted Annual Revenue and Expenditure Report

Program Name	Prior Program Name in ARER	Ages*
Full-Service Partnership		
Youth and Family (Y&F) FSP	Youth FSP	0-21
Insights	Youth FSP	0-18
Transitional Age Youth (TAY) Outpatient Treatment Program	TAY FSP	16-25
Casa Esperanza TAY Transitions Program (TAY FSP)	TAY FSP	16-25
Assisted Outpatient Treatment (AOT) Program – (Laura's Law)	Assist (Laura's Law)	18+
VCBH Adult FSP Treatment Program	Adult FSP Program	18+
Empowering Partners through Integrative Community Services (EPICS)	Older Adults FSP Program	60+
VISTA	Adult FSP Program	18+
VCBH Older Adults FSP Program	Older Adults FSP Program	60+
Outreach & Engagement		
Rapid Integrated Support and Engagement (RISE)	N/A, no name change	All
Crisis Intervention/Stabilization		
County-Wide Crisis Team (CT)	N/A, no name change	All
Crisis Care Mobile Units (CCMU) Grant	N/A, no name change	All
Crisis Residential Treatment (CRT)	N/A, no name change	18-59
Crisis Stabilization Unit (CSU)	N/A, no name change	6-17
Individual Needs Assessment		
Screening, Triage, Assessment, and Referrals (STAR)	N/A, no name change	All
Treatment		
Fillmore Community Project	N/A, no name change	0-18
Transitional Age Youth (TAY) Outpatient Treatment Program	Transitional Age Youth (TAY) Outpatient (Transitions)	18-25
VCBH Adult Outpatient Treatment Program	Adult Treatment (Non-FSP)	18+
Linguistics Competence Services	N/A, no name change	All
Peer Support		
The Client Network	N/A, no name change	All
Family Access Support Team (FAST)	N/A, no name change	All
Growing Works	N/A, no name change	18+
Adult Wellness and Recovery Center and Mobile Wellness	Adult Wellness Center – Turning Point	26+
TAY Wellness Center	TAY Wellness Center - Pacific Clinics	16-25
MHBG-Peer Support (CRSSA/ARPA)	N/A, no name change	All
Access Support		
Forensic Pre-Admit/Mental Health Diversion Grant Program	N/A No name change	All
Housing	Adult Treatment (Non-FSP)	18+

COMMUNITY SERVICES AND SUPPORTS (CSS)

Data Notes and Definitions – Mental Health Treatment (FSP and Non-FSP)

The following definitions and notes below apply to data collection from the Electronic Health Record (EHR) using the Avatar system.

Served Client is defined as anyone with a service code billed by an FSP or non-FSP MHSA treatment program in the fiscal year who was not in an FSP treatment track at the time of service.

The words **Client** and **Partner** are used interchangeably.

Service codes include no-show service codes.

Service codes must be associated with an FSP or non-FSP episode in a MHSA treatment program that was open in the fiscal year.

Service is attributed to the billing program (not always the same as the program to which the episode is open).

Insights is counted as an FSP treatment track for Youth and Family.

Rollover Client is defined as a served client whose episode admission to an FSP or non-FSP MHSA treatment program through which services were rendered during the fiscal year prior to July 1, 2021.

New Client is defined as a served client whose first episode admission to a FSP or non-FSP MHSA treatment program through which services were rendered during the fiscal year was July 1, 2021, and after.

Age Group Total may not manually add up to the unduplicated client total since clients may have advanced in age and may have moved from one age group to another within the same fiscal year.

Program Total may not manually add up to the unduplicated client total because clients may have been served under more than one program within the same fiscal year and were/are counted under each program in which services were rendered.

The demographic information below is pulled from the first episode occurring in a FSP or non-FSP MHSA program during the fiscal year. If there were multiple entries in an episode, the last entry for the episode was used.

Age is calculated at the date of service for each billed service.

Gender varies by MHSA component.

Preferred Language is the language selected for receiving services.

Ethnicity varies by MHSA component.

Gender Identity varies by MHSA component.

Race Totals may not equal the unduplicated client total as clients may select more than one race (up to five).

Sexual Preference varies by MHSA component.

Disability was not collected for this program at this time.

Veteran status was not collected for this program at this time.

City of Residence varies by MHSA component.

Service Units Categories are based on VCBH-defined groupings for billing. The “Medication Support MC Billable” category was relabeled as “Evaluation and Management” to be more descriptive of the underlying service codes.

Please note: Percentages may not equal to exactly 100% due to rounding. Also, not all numerators will match unduplicated client counts due to multiple entries by clients.

*Programs span a wide range of ages, and every effort was made to present data according to regulations’ requirements.
** Programs were combined in Fiscal Year 2020-2021.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Full-Service Partnerships (FSP)

Full-Service Partnership (FSP) programs are designed for all age groups and would benefit from an intensive service program. The foundation of Full-Service Partnerships is doing everything possible to help individuals on their path to recovery and wellness. Full-Service Partnerships are designed to be client driven and are based on an individual's needs.

FSP Programs Target Goals for Fiscal Year 2024-2025

Program	Target Served	Projected cost per client
Youth FSP Intensive Case Management (launching FY 25-26)	53	16,228
Child Welfare System - FSP (launching FY 25-26)	0	N/A
Transitional Age Youth (TAY) Expanded Transitions Program	150	1,415
Casa Esperanza TAY Transitions Program	12	52,202
Assisted Outpatient Treatment (AOT)	120	6,725
CARE ACT (launching 24/25)	25	25,057
Empowering Partners through Integrative Community Services (EPICS)	90	14,742
Telecare VISTA	50	24,005
VCBH Adult FSP Treatment Program	25	3,435
Adult Clinic Based FSP (New)	150	5,662
VCBH Older Adults FSP Program	100	21,398

COMMUNITY SERVICES AND SUPPORTS (CSS)

Full-Service Partnership

Program Demographics - Unduplicated Clients

Age Group	**N = 531**	
0 - 15 yrs.	23	4.33%
16 - 25 yrs.	72	13.56%
26 - 59 yrs.	278	52.35%
60 yrs & Older	158	29.76%
Gender Identity	**N = 520**	
Female	224	43.08%
Male	296	56.92%
Race	**N = 489**	
White/Caucasian	229	46.83%
Black/African American	26	5.32%
Asian	10	2.04%
Alaska Native or Native American	3	0.61%
Other	221	45.19%
Sexual Orientation	**N = 73**	
Bisexual	3	4.05%
Heterosexual / Straight	70	94.59%
Declined to Answer	1	1.35%
Ethnicity	**N = 482**	
Hispanic	207	42.95%
Non-Hispanic	274	56.85%
More Than One Ethnicity	1	0.21%
Language Spoken	**N = 523**	
American Sign Language (ASL)	2	0.38%
Arabic	1	0.19%
English	483	92.35%
Other non-English	1	0.19%
Spanish	36	6.88%
Military Serviced	**N = 45**	
No	45	100.00%
Disabilities	**Not Collected**	

Program Demographics

FY 23-24 Total Program Cost		$ 778,467
Total Individuals Served		53
Cost per Individual:		$14,688
Individuals Served FY 22-23		8
Age Group	**N = 53**	
0 - 15 yrs.	22	41.51%
16 - 25 yrs.	31	58.49%
Gender Identity	**N = 50**	
Female	24	48.00%
Male	26	52.00%
Race	**N = 51**	
White/Caucasian	26	50.98%
Black/African American	1	1.96%
Other	24	47.06%
Sexual Orientation	**N = 15**	
Heterosexual / Straight	15	100.00%
Ethnicity	**N = 48**	
Hispanic	34	70.83%
Non-Hispanic	14	29.17%
Language Spoken	**N = 53**	
English	43	81.13%
Spanish	10	18.87%
Veteran	**N = 20**	
No	20	37.74%
Unknown / Not Reported	33	62.26%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

Over the past year, the ATLAS Youth and Family program has continued to expand providing Full-Service Partnership level services to diverse, underserved communities across Ventura County. By utilizing a combination of clinic-based and field-based clinicians, case managers, and peer support specialists the program has increased outreach to marginalized populations. Staffing field-based clinicians has posed a challenge; however, the program effectively supplemented this through temporary staffing agencies. Staff meet clients wherever needed – homes, schools, churches, libraries, etc. – to deliver FSP services. Progress in staffing has enabled the program to expand field-based services and increase clinic census. Clinicians, MHAs and Peer Support Specialists provide field services and have enhanced client support through funding for basic needs like housing and clothing. Despite challenges, ATLAS remains dedicated to high-frequency, collaborative community services, prioritizing equitable, inclusive, and culturally informed care. The team regularly uses interpretation and/or bilingual staff services to help clients access and navigate services in their native language, strengthening accessibility and familiarity with the program offerings.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

For fiscal year 23-24, ATLAS continues to make strides in addressing key community needs and specific areas highlighted in the CPP from the point of client referral. To improve targeted support, each referral has been categorized by key risk factors such as homelessness and justice involvement, allowing staff to quickly focus on priority areas impacting youth. This year, the program enhanced comprehensive services to housing assistance, increased field based mental health support, elevated case management support and community connectedness. This has fostered greater stability for the youth and their families. ATLAS has also continued to develop and strengthen collaborations with law enforcement, public health, probation, juvenile facilities, etc. to support reentry programs that reduce recidivism and foster long-term progress. Outreach continues to actively engage with underserved communities, ensuring that culturally competent care and reduced barriers, such as language, transportation, etc. are at the forefront of program support. By tailoring services to meet the unique needs of each client, ATLAS is committed to reducing disparities and improving community outcomes.

Include examples of notable community impact.

ATLAS FSP continues to make significant community impact by helping clients become housed, reducing recidivism and enhancing access to mental health services for underserved populations. By collaborating with community and agency partners we are supporting clients in prioritizing basic needs to better support functioning and family stability. The program offers additional support with housing including two mental health associates with the ability to enter families and clients into the HMIS system and actively and effectively address homelessness. With focus on culturally relevant services and field based, high frequency, multi-disciplinary supports ATLAS reduces barriers for underserved populations, strengthens family resilience and promotes well-being throughout the community.

Success story.

ATLAS was able to support housing a single mother and her 3 children fleeing a domestic violence situation. The three children have vocalized finally feeling safe and are actively participating in mental health treatment. Mother is also working on accessing her own therapy services as well. Mother regularly meets with FSP case managers to support identifying basic needs and community resources to support.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Full-Service Partnerships (FSP)

Insights

Program Demographics

FY 23-24 Total Program Cost		$ 243,283
Total Individuals Served		13
Cost Per Individual:		$ 18,714
Individuals Served FY22-23		17
Age Group	**N = 13**	
16 - 25 yrs.	13	100.00%
Gender Identity	**N = 13**	
Female	6	46.15%
Male	7	53.85%
Race	**N = 13**	
White/Caucasian	8	61.54%
Other	5	38.46%
Sexual Orientation	**N = 5**	
Heterosexual / Straight	3	100.00%
Ethnicity	**N = 12**	
Hispanic	9	75.00%
Non-Hispanic	3	25.00%
Language Spoken	**N = 13**	
English	13	100.00%
Veteran	**N = 13**	
No	13	100.00%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable

For FY 23-24 Insights continued its efforts to enhance service accessibility and reduce ethnic and cultural disparities within the community, supporting underserved justice involved youth through enhanced collaborative efforts with multiple partnering agencies. The program focused on improving referral acceptance processes with the intention to grow the program census allowing more probation youth to access collaborative mental health, substance use, public health, juvenile court, probation, school and parent partner services. However, despite these efforts the program faced ongoing challenges due to low census of formal probation youth leading to its closure in FY 23-24.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

During FY 23-24, the Insights program actively worked to address community issues highlighted in the County's CPPP, such as reducing youth incarceration, supporting underserved groups, and enhancing field-based services. Coordination of high-level management discussions as well as original Insights members continued into FY 23-24 and agencies discussed ways to increase census while maintaining limited court involvement to support the program goals, reduce recidivism to retain program knowledge and support. Despite challenges with partner consensus of changes in eligibility criteria impacting census growth, Insights continued to explore referral pathways and potential program expansion to better service the community's needs and CPPP goals. All while continuing to engage active clients in high frequency service support.

Include examples of notable community impact

The Insights program addressed critical community issues through supporting youth involved in the justice system. Insights collaborated closely with the juvenile court, public defenders, probation, and other partners to improve clients access to services and increase collaboration between service providers. The program ensured youth have ongoing access to mental health and substance use services aiming to reduce deeper justice involvement. Insights also addressed essential needs by providing transportation assistance for court appointments. Additionally, Insights organized regular meetings with providers and stakeholders, fostering a coordinated approach that encouraged engagement and community integration in an attempt to enhance outcomes for young people.

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Insights

Success story.

Despite Insights closing we were able to support one of the final youths in full graduation of the program on the last official day of Insights court. This meant that the youth no longer had as restrictive requirements from probation and the client was able to continue with current mental health and community providers as needed.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Full-Service Partnerships (FSP)

Transitional Age Youth (TAY) Expanded Transitions Program – FSP (TAY FSP)

Program Demographics

FY 23-24 Total Program Cost		**$ 196,038**
Total Individuals Served		21
Cost Per Individual:		$ 9,335
Individuals Served FY22-23		11
Age Group	**N = 21**	
16 - 25 yrs.	18	85.71%
26 - 59 yrs.	3	14.29%
Gender Identity	**N = 21**	
Female	7	33.33%
Male	14	66.67%
Race	**N = 20**	
White/Caucasian	4	20.00%
Black/African American	2	10.00%
Other	14	70.00%
Sexual Orientation	**N = 2**	
Heterosexual / Straight	2	100.00%
Ethnicity	**N = 19**	
Hispanic	14	73.68%
Non-Hispanic	5	26.32%
Language Spoken	**N = 21**	
English	21	100.00%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The program strives to provide services to underserved populations in the 18-25 age range. TAY staff are available to provide services in both English and Spanish and a certified interpreter or language line services are used for other non-threshold languages. In person interpretation is always prioritized. This communication helps to provide comprehensive cultural and linguistic services, so the needs of the clients are better understood. It also identifies what the barriers are for care coordination and how to best support/educate clients and their families, so clients feel supported and heard. TAY staff have more frequent contacts with the FSP level clients due to increased need. TAY staff regularly have training and discussions about disparities in care and how to bridge the gaps for the clients. Cultural considerations are regularly discussed in treatment team meetings so that all team members can gain an understanding and learn from clients and peers about what the need will be to participate in and access care. One of the challenges identified has been to increase TAY services across Ventura County and expand the service areas so that the most culturally and linguistically competent services are provided to the most impacted residents.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

To best serve the County's most vulnerable populations, programs need to have a healthy, patient, and informed workforce. Staff shortages and turnover make it challenging to provide the best care to the most in-need clients, however, over the course of the fiscal year this has improved. TAY staff work regularly with community partners and agencies to coordinate client care and address unmet needs.

Include examples of notable community impact.

Emphasis on FSP level of care to the most vulnerable populations to meet the needs of our County's diverse racial, ethnic, and cultural communities are being made for this population. Expanding TAY FSP services to the entire county will be the focus over the next fiscal year.

Success story.

We have a TAY FSP client that successfully transitioned out of services after being with TAY for a couple of years. Client was able to obtain employment, obtain stable housing, has been medication compliant, and meet his independent living goals after years of instability where he was chronically homeless, disengaged, and was mentally unstable for several years prior to TAY FSP. He was able to build a strong relationship with his case manager, which was an important part of his healing process.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Full-Service Partnerships (FSP)

Casa Esperanza TAY Transitions Program (TAY FSP)

Program Demographics

FY 23-24 Total Program Cost		**$1,167,190**
Total Individuals Served		12
Cost Per Individual:		$97,266
Individuals Served FY22-23		11
Age Group	**N = 12**	
16 - 25 yrs.	11	91.67%
26 - 59 yrs.	1	8.33%
Gender Identity	**N = 12**	
Female	7	58.33%
Male	5	41.67%
Race	**N = 12**	
White/Caucasian	4	33.33%
Black/African American	1	8.33%
Other	7	58.33%
Sexual Orientation	**N = 1**	
Heterosexual / Straight	1	100.00%
Ethnicity	**N = 11**	
Hispanic	6	54.55%
Non-Hispanic	5	45.45%
Language Spoken	**N = 12**	
English	12	100.00%
Veteran	**N = 1**	
No	1	100.00%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The CASA FSP program is unique in that clinical services are provided by VCBH outpatient clinical team members while clients reside at the Casa Esparanza campus for up to 18 months. While living there, they engage in rehabilitative programs such as improving functional impairments, learning job skills, and focusing on mastering independent living skills, so clients can be successful in the community when they graduate from the program. Cultural considerations and unique mental health needs are regularly discussed so all team members can gain an understanding of the barriers that clients are facing and help create a plan to overcome those barriers so they may be successful in the community when they leave the program. Challenges in the community include access to supportive housing and resources upon discharge.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

To best serve the County's most vulnerable populations, programs need to have a healthy, patient, and informed workforce. Staff shortages and turnover with the contracted provider make it challenging to provide the best care for the greatest number of clients.

Include examples of notable community impact.

After clients spend 12-18 months in the program, they are better equipped to navigate emerging adulthood. Clients work on skill building and social skills so that they can be successful in entering or finishing school or obtaining/maintaining employment.

Success story.

During FY 23-24 a client successfully graduated Case De Esperanza and transitioned to the California Conservation Corps. Client was able to live independently and maintain his mental health and healthy relationships. He was very vulnerable prior to entering this program and was mentally unstable, which included poor interpersonal relationships, multiple psychiatric hospitalizations, prior suicide attempts, and engaged in self-harming regularly. His recovery is ongoing, and the staff is proud of his progress.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Full-Service Partnerships (FSP)

Assisted Outpatient Treatment (AOT) Program

Program Demographics

FY 23-24 Total Program Cost		**$ 1,804,229**
Total Individuals Served		122
Cost Per Individual:		$ 14,788
Individuals Served FY22-23		69
Age Group	**N = 122**	
16 - 25 yrs.	15	12.30%
26 - 59 yrs.	98	80.33%
60 yrs & Older	9	7.38%
Gender Identity	**N = 117**	
Female	39	33.33%
Male	78	66.67%
Race	**N = 109**	
White/Caucasian	40	36.70%
Black/African American	7	6.42%
Asian	2	1.83%
Other	60	55.05%
Sexual Orientation	**N = 10**	
Heterosexual / Straight	10	100.00%
Ethnicity	**N = 102**	
Hispanic	47	46.08%
Non-Hispanic	54	52.94%
More Than One Ethnicity	1	0.98%
Language Spoken	**N = 115**	
English	111	90.98%
Spanish	2	1.64%
American Sign Language (ASL)	1	0.82%
Other non-English	1	0.82%
Unknown / Not Reported	7	5.74%
Veteran	**N = 5**	
No	5	4.10%
Unknown / Not Reported	117	95.90%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The AOT program had several successful graduations this year. Clients were able to step down to lower level of care (outpatient clinics), and one client (who was not resistant to services), was transferred to the clinic based FSP program. The program had two clients who were able to find and maintain jobs in the community. The AOT team meets with the clients 2-3 times per week, which leads to an increase in better rapport and engagement. In addition, during this FY23-24, the AOT program petitioned 27 clients to county court.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The AOT team started using petitions to the county court as a tool to assist with increased services utilization. During FY23-24, of the 27 petitions filed, 20 were granted. The AOT team is working to identify and evaluate clients that resist treatment and need to be petitioned to the court in order to assist them in recovery. In addition, as the need for housing rose, the AOT team was able to find housing for 100% of their clients. AOT also worked very closely with the incompetent to stand trial (IST) court, to screen IST referrals to AOT services. Clients who were found eligible for the program filed the appropriate petition.

Include examples of notable community impact

The AOT team collaborates with several community stakeholders. This includes police departments, jails, hospitals, the IST court, and community well-care providers. This will help increase client enrollment and monitoring, connecting them to services they need. Our goal is to ensure that all clients are using services and engage in treatment.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Full-Service Partnerships (FSP)

VCBH Adult Clinic-Based FSP Treatment Program

Program Demographics

FY 23-24 Total Program Cost		**$ 236,503**
Total Individuals Served		61
Cost Per Individual:		$ 3,877
Individuals Served during FY 22-23		93
Age Group	**N = 61**	
16 - 25 yrs.	2	3.28%
26 - 59 yrs.	46	75.41%
60 yrs & Older	13	21.31%
Gender Identity	**N = 61**	
Female	26	42.62%
Male	35	57.38%
Race	**N = 60**	
White/Caucasian	31	51.67%
Black/African American	4	6.67%
Alaska Native or Native American	0	0.00%
Other	25	41.67%
Sexual Orientation	**N = 17**	
Bisexual	3	17.65%
Heterosexual / Straight	14	82.35%
Ethnicity	**N = 59**	
Hispanic	23	38.98%
Non-Hispanic	36	61.02%
Language Spoken	**N = 61**	
English	60	98.36%
Spanish	1	1.64%
Veteran	**N = 11**	
No	11	18.03%
Unknown / Not Reported	50	81.97%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

Clinic Based FSP continues to make progress in addressing the needs of the unserved and underserved populations, with a strong focus on reducing ethnic and cultural disparities by identifying key risk factors such as homelessness, justice involvement and acute mental health needs from the point of referral, and as a result the program has been able to provide targeted multidisciplinary support. This year, Adult FSP has strengthened its collaboration with housing providers, medical providers, hospitals, and other community partners to enhance stabilization services and long-term client success. Additionally, the program has expanded its focus on adjunct stabilization services, offering intensive case management, alcohol and drug treatment support, and integrated evidenced based treatment approaches to ensure clients receive full spectrum of care. A key challenge this year has been staffing shortages and turnover, particularly in securing field-based staff. Despite this, the team has worked diligently to mitigate challenges through creative staffing solutions and continued efforts to recruit and retain qualified professionals. By prioritizing culturally responsive, client centered care and reducing barriers to treatment such as language and transportation, Clinic Based FSP is committed to fostering long-term stability for priority populations.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

Clinic Based FSP services have had a continued meaningful impact on the community by addressing homelessness, reducing justice involvement and expanding access to behavioral health services for our unserved and underserved populations. Through strong collaboration with community partners, social service agencies, and housing resources the program can assist clients in securing stable housing, accessing needed healthcare services and linking clients to basic needs supports to promote recovery and independence. The team includes a multidisciplinary dedicated staff whose focus of service is intensive, culturally responsive and field based. Clinic Based FSP works to remove barriers for individuals facing severe mental illness to promote stability and overall well-being. The program assists with adjunct services supporting high collaboration with treatment providers, crisis team, housing facilities etc. to create a seamless coordination of care.

Include examples of notable community impact.

The Clinic Based Full-Service Partnership program strives to make a significant impact in the community by targeting critical issues our clients face such as homelessness, mental health crisis and reducing justice involvement and utilization of emergency services. Through intensive case management, housing support, crisis intervention and therapeutic services the program has seen clients succeed in managing their symptoms and demonstrating increased functioning in the community setting. By collaborating with the different health care providers, law enforcement agencies, supports persons and various other entities in our clients' lives, the CB FSP continues to work to ensure comprehensive and culturally responsive care that improves client outcomes and quality of life.

Success story.

The clinic-based FSP team successfully supported a middle-aged female client with a history of multiple incarcerations and chronic homelessness in securing stable housing. With guidance, the client applied for and received Social Security benefits, providing a foundation for financial stability. Additionally, the client continues engagement in psychiatric and therapeutic treatment, leading to improved insight and overall mental health. The client meets with their FSP case manager weekly to address ongoing needs and connect with necessary resources for continued support.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Full-Service Partnerships (FSP)

VCBH Adult FSP Treatment Program

Program Demographics

FY 23-24 Total Program Cost		$ 343,590
Total Individuals Served		32
Cost Per Individual:		$ 10,737
Individuals Served during FY 22-23		N/A
Age Group	**N = 32**	
16 - 25 yrs.	2	6.25%
26 - 59 yrs.	26	81.25%
60 yrs & Older	4	12.50%
Gender Identity	**N = 32**	
Female	13	40.63%
Male	19	59.38%
Race	**N = 31**	
White/Caucasian	13	41.94%
Alaska Native or Native American	1	3.23%
Other	17	54.84%
Sexual Orientation	**N = 7**	
Heterosexual / Straight	7	100.00%
Ethnicity	**N = 32**	
Hispanic	15	46.88%
Non-Hispanic	17	53.13%
Language Spoken	**N = 32**	
English	31	96.88%
Spanish	1	3.13%
Veteran	**N = 2**	
No	1	3.23%
Unknown / Not Reported	30	96.77%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

In Fiscal Year 2023-2024, VCBH continued to serve FSP clients using "whatever it takes" funds. Despite not having a fully integrated clinic based FSP at the Adult Outpatient Clinics (Conejo Valley, Santa Paula, Simi Valley, Oxnard, South Oxnard and Ventura). Clients in the FSP treatment track obtained clinical support addressing their individual needs. The goal was to get an accurate and up to date account of all clients that qualified for a Full-Service Partnership and to fully integrate the clients into the program so they can best be served. The migration to SmartCare (new EHR) came with a few adjustments including the ability to update Key Events and PAF's directly into the EHR.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

Clinic based FSP works with Ventura County's clients who have a severe mental illness who would benefit from an intensive service program. This includes clients who are experiencing homelessness, incarceration, and/or psychiatric hospitalizations. The clinic based FSP assists clients with housing, employment, and substance use. The program provides an integrated treatment experience for individuals who may have co-occurring mental health and substance abuse disorder.

Include examples of notable community impact.

The Full-Service Partnership track has been instrumental in being able to provide resources to the community members who struggle with mental illness. It has assisted all of our Adult Outpatient clinics in providing resources that have contributed significantly to the stabilization of clients. We have been able to assist clients with being housed in Sober Living homes. This has been helpful for clients who are struggling with co-occurring disorders in living in an environment that supports their sobriety, while they are continuing to address their mental health needs.

Success story.

M.B. is a 27-year-old female client who has been receiving FSP services from the Conejo Valley Adult Clinic. She has struggled with severe anxiety, depression, and maintaining a stable mood. These difficulties have significantly contributed to suicidal ideations and have led to a history of suicide attempts. Since being enrolled in our FSP program, she has been receiving additional clinical support from staff and case management personnel, who have assisted in efforts to improve her symptoms. She is now able to attend college and maintain employment. FSP funds have also been used to retrieve her vehicle after it was mistakenly towed following her hospitalization, which helped in her re-stabilization as she returned to her normal life activities.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Full-Service Partnerships (FSP)

Empowering Partners through Integrative Community Services (EPICS)

Program Demographics

FY 23-24 Total Program Cost		**$ 1,617,815**
Total Individuals Served		93
Cost Per Individual:		$17,396
Individuals Served FY22-23		83
Age Group	**N = 93**	
16 - 25 yrs.	2	2.15%
26 - 59 yrs.	61	65.59%
60 yrs & Older	30	32.26%
Gender Identity	**N = 93**	
Female	38	40.86%
Male	55	59.14%
Race	**N = 93**	
White/Caucasian	49	52.69%
Black/African American	5	5.38%
Asian	4	4.30%
Alaska Native or Native American	1	1.08%
Other	34	36.56%
Sexual Orientation	**N = 16**	
Heterosexual / Straight	15	93.75%
Declined to Answer	1	6.25%
Ethnicity	**N = 89**	
Hispanic	27	30.34%
Non-Hispanic	62	69.66%
Language Spoken	**N = 93**	
English	90	96.77%
Spanish	3	3.23%
Veteran	**N = 2**	
No	2	100.00%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

Empowering Partners through Integrative Community Services (EPICS) offers intensive, comprehensive, voluntary services to clients who struggle with severe and persistent mental illness. With small caseloads, the EPICS staff can provide additional time for their clients in the community and provide direct field support. EPICS works together as a team with clients that are both under and unserved. Clients are often unhoused or in temporary arrangements. These arrangements include but are not limited to jail, hospitals, skilled nursing facilities, staying with friends or family. The EPICS team is knowledgeable and aware of ethnic and cultural disparities. Oftentimes, clients speak English while their family members speak Spanish. EPICS considers the needs of these clients and plans so client families can be included and part of the conversation. The EPICS team advocates for their clients and continues to work with clients through relapses in behavior and drug abuse. The EPICS team has access to our Basic Needs and Housing fund. These funds are for safety, a place to live, food, medical needs, transportation etc. When clients' basic needs are met, they experience fewer stressors which impact their client and their family. One of the primary stressors in a client's life is not taking medications consistently. Our team of nurses offer client/family education on medication management which is offered to the client and family if they are open to it. The team provides transportation to the psychiatrist's office to ensure full support is provided. The team of nurses ensure that clients meet their medical needs. The EPICS program supports clients that struggle with difficult symptoms. Staff are trained to meet the clients where they are and provide the rehabilitation services needed

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The EPICS program serves the whole community. The program collaborates with community programs which support the client to receive a full array of services. Services include clients placed in housing, furnishing, and support to the client in navigating the community. Staff and clients practice together to develop their self-sufficiency and meet their treatment goals.

Include examples of notable community impact.

Building rapport and trust within the community is central to the success of the EPICS program. The EPICS team is empathetic and takes time to make trusting connections. The team understands clients may have many simultaneous needs including time, legal or medical issues, and experience crisis. The EPICS team members seek to balance support and teach clients how to access the support available to them.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Full-Service Partnerships (FSP)

VISTA (Adults FSP Program)

Program Demographics

FY 23-24 Total Program Cost	**$ 1,308,449**	
Total Individuals Served	63	
Cost Per Individual:	$ 20,769	
Individuals Served FY22-23	34	
Age Group	**N = 63**	
16 - 25 yrs.	2	3.17%
26 - 59 yrs.	53	84.13%
60 yrs & Older	8	12.70%
Gender Identity	**N = 61**	
Female	11	18.03%
Male	50	81.97%
Race	**N = 60**	
White/Caucasian	23	38.33%
Black/African American	2	3.33%
Asian	2	3.33%
Other	33	55.00%
Sexual Orientation	**N = 7**	
Heterosexual / Straight	7	100.00%
Ethnicity	**N = 57**	
Hispanic	30	52.63%
Non-Hispanic	27	47.37%
Language Spoken	**N = 63**	
English	56	88.89%
Spanish	7	11.11%
Veteran	**N = 5**	
No	5	100.00%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The program hired a dedicated therapist and was fully staffed in the last fiscal year, which helped expand the services provided in the community. The program has strengthened their Recovery-Centered Clinical System (RCCS) programming by providing weekly training to staff and intentional RCCS programming to the clients. RCCS is intended to awaken the clients' hopes and dreams, providing knowledge to reclaim their power, learning to make choices that reinforce their self-control, self-responsibility, and self-determination. The clinical team is trained and certified in placing holds to continue to provide support to our clients and the community partners who assist us during those moments of crisis. The program continued to adjust to the implementation of CalAIM and SmartCare, the county's new County Electronic Health Record.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The program works specifically with the unhoused, incarcerated, and underserved/unserved groups. The team includes case managers, nurses, prescribers, therapists, and peers who support clients in becoming independent, supporting their medication regimes, accessing social support, participating in educational groups, obtaining benefits or employment, and learning life skills. Supportive housing assistance is also provided. Services are delivered in person, in the community, in the office, or via telehealth. The program reaches out to clients for several weeks to build rapport and meet them where they are most comfortable. Gradually, staff engage them in services to reduce recidivism, housing security, and help them become independent citizens of their community.

Include examples of notable community impact.

Last year, the program focused on increasing the relationship with the public defender's office and the jail staff to improve communication around releases for high-risk clients. The program was able to coordinate multiple releases, in collaboration with sentencing specialists, jail staff, and the public defender's office. This has helped our higher risk clients be connected to community services directly from jail, versus being released on their own recognizance. This ensured that the clients would be housed, receive medication timely, and have support from our treatment team on day one. Last year the program also focused on increasing their relationships with the community Sober Living homes. This in turn helps clients, as Sober Living homes are more open to housing our clients if they know they have a supportive team working with them. Sober Living homes are also more open to refunding monies back to clients in order to rehouse them, and to continue to support them if they break house rules, such as relapsing.

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

VISTA (Adults FSP Program)

Success story.

When a client was initially referred to the program, the client had frequent suicide ideation (SI), was frequently hospitalized, had difficulty maintaining relationships, difficulty maintaining housing, and did not follow through with the medication recommendations. Through ongoing support from the team and his personal efforts to excel in his life, he overcame these challenges. For the last year he has had no SI, is taking his medication as prescribed, through therapy is addressing his anxiety and past traumas, has a 3.5 GPA at school, and has learned to advocate for himself. He is currently working on writing a script about his life and continuing to pursue a degree in Literature. He has employment and is able to continue to fund his housing. He has also contributed back to the Supportive Housing Funds. He has successfully graduated from the program and made progress in his treatment.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Full-Service Partnerships (FSP)

VCBH Older Adult FSP Program (Older Adults FSP Program)

Program Demographics

FY 23-24 Total Program Cost		**$ 2,673,666**
Total Individuals Served		91
Cost Per Individual:		$ 29,381
Individuals Served FY22-23		89
Age Group	**N = 91**	
60 yrs & Older	91	100.00%
Gender Identity	**N = 91**	
Female	68	74.73%
Male	23	25.27%
Race	**N = 70**	
White/Caucasian	45	64.29%
Black/African American	2	2.86%
Asian	2	2.86%
Alaska Native or Native American	1	1.43%
Other	20	28.57%
Sexual Orientation	**N = 4**	
Heterosexual / Straight	4	100.00%
Ethnicity	**N = 85**	
Hispanic	21	24.71%
Non-Hispanic	64	75.29%
Language Spoken	**N = 91**	
English	81	89.01%
Spanish	9	9.89%
Arabic	1	1.10%
Veteran	**N = 2**	
No	2	100.00%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The primary mission objective for Older Adult Population is addressing the needs of the unserved and underserved mentally ill seniors in our community. Older Adults is a field-based program which provides home based services for those who would otherwise not get needed treatment. Transportation and social isolation are two of the top challenges for seniors of all cultures and the Older Adult Program is constantly coming up with creative ways to reach these multi-cultural elderly clients.

Here are examples of how the Older Adults program has overcome some of the disparities facing an isolated multi-ethnic population and increasing social and cultural integration:

• Expanded the availability of group therapy that is now available in both of the local RCFEs (Residential Care Facilities for Elderly). These groups happen on a weekly basis and promote communication and socialization within a multi-cultural group leading to a stronger sense of community with its members

• Older adults having access to psychiatric services has long been a roadblock to reducing mental health symptoms and improving overall functioning. This past year we partnered with Community Memorial Psychiatric Residency Program and launched a new program in which 4th year psychiatric residents rotate providing in-person home-based psychiatric services to seriously mentally ill seniors.

• The Older Adult Program continued the recovery from the pandemic by expanding the end of year holiday events which included a festive holiday meal in which multi-cultural celebrations took place and created a calendar which exhibited the artwork created by diverse contributors and shared with all Older Adult clients increasing the sense of community and proving another outlet for expression.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

There is no greater fear for an older adult than the threat of losing their home which is often exacerbated by the presence of a severe mental illness. This year we were able to initiate and implement a housing supplement program for those living in mobile home parks who are paying more than 30% of their fixed income on housing. Mobile home parks are not regulated in what can be charged for rental of the space and some of our seniors were unable to pay for basic needs such as food, medicine and clothing because their rental costs consumed most of their fixed monthly

income. With this new program, their monthly rental costs are capped at 30% and supplemented with housing funds thereby reducing the risk of homelessness.

Include examples of notable community impact.

This Clinic Administrator participates in and represents Behavioral Health Older Adults at the RRET (Rapid Response Expert Team) which is a twice a month meeting hosted by Adult Protective Services and comprised of multiple agencies including Public Health, Law Enforcement, Public Guardian, Neuropsychologist team, victim's advocates and others. This team is able to take on critical cases and engage multiple agencies to more quickly and effectively address the needs and crises of the underserved.

Success stories.

Prior to coming to the Older Adult Program, T.O. had an extensive history of substance use and homelessness. She was dually diagnosed with Major Depression and alcoholism which cost her career and left her homeless. After coming to the Older Adult Program, she was able to maintain sobriety, treat her clinical depression and get admitted to an RCFE (Residential Care Facility for the Elderly) which provided enough stability for her that she was able to regain a level of functioning that had been lost to her. Working with the Older Adult case manager, she was able to apply for and obtain subsidized housing through the Housing Authority and is working toward independent living.

"I'm looking forward to cooking!" T.O. was excited to be able to have an opportunity to get involved with gardening at the housing unit and hopes to someday re-unite with family members that she had become estranged from, particularly a granddaughter. She was linked to Independent Living Resource Center to furnish the new housing unit.

This was a community effort led by Older Adults that restores the dignity and independence of an older adult client who while needing ongoing support has been able to participate in her own recovery because of resources made available to her.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Outreach and Engagement (O & E)

This Community Services and Supports (CSS) category employs strategies and resources to reach, identify, and engage unserved individuals and communities in the County mental health system with the goal of reducing disparities unique to the County. In addition to reaching out to and engaging several entities, such as community-based organizations, schools, primary care providers, and faith-based organizations, this category of programs engages community leaders, the homeless population, those who are incarcerated, and families of individuals served.

The Outreach and Engagement (O & E) category under CSS is fulfilled by the Rapid Integrated Support and Engagement (RISE) program that assigns various staff to do concentrated outreach to eligible individuals who have difficulty engaging with services. In addition to the RISE program, there are general outreach efforts executed countywide to inform and engage the community regarding mental illness and services available.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Rapid Integrated Support and Engagement (RISE)

Program Demographics

FY 23-24 Total Program Cost		**$ 2,269,917**
Total Individuals Served		1,107
Cost Per Individual:		$ 2,051
Individuals Served during FY 22-23		1,317
Age Group	**N = 1,107**	
0 - 15 yrs.	30	2.71%
16 - 25 yrs.	252	22.76%
26 - 59 yrs.	636	57.45%
60 yrs & Older	189	17.07%
Gender Identity	**N = 858**	
Female	404	47.09%
Male	449	52.33%
Female-to-Male (FTM)/Transgender Male/Trans Man	2	0.23%
Male-to-Female (MTF)/Transgender Female/Trans Woman	2	0.23%
Other	1	0.12%
Race	**N = 665**	
White/Caucasian	292	43.91%
Black/African American	29	4.36%
Asian	8	1.20%
Native Hawaiian or Other Pacific Islander	1	0.15%
Alaska Native or Native American	3	0.45%
Other	332	49.92%
Sexual Orientation	**N = 81**	
Bisexual	2	2.47%
Gay (male)	2	2.47%
Heterosexual / Straight	74	91.36%
Transgender	1	1.23%
Declined to Answer	2	2.47%
Ethnicity	**N = 618**	
Hispanic	303	49.03%
Non-Hispanic	315	50.97%
Language Spoken	**N = 840**	
English	770	91.67%
French	1	0.12%
Other non-English	1	0.12%
Spanish	67	7.98%
Tagalog	1	0.12%
Veteran	**N = 54**	
Yes	2	3.70%
No	52	96.30%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

Rapid Integrated Support and Engagement (RISE) is an outreach and engagement program that reaches out to individuals who have difficulty connecting to services, fall through cracks in the system, and have traditionally been underserved within the behavioral health system of care. RISE works to identify barriers to treatment and build bridges to true linkage to services. RISE provides services to all individuals within Ventura County who need to be connected to a variety of resources, which include but are not limited to behavioral health services. RISE services are defined as any outreach contact that is provided to an individual to help connect them to the appropriate treatment provider or community resource. The RISE team are bilingual and bicultural – providing direct support in the individuals' native language.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The RISE team members work closely with local community partners such as law enforcement (LE), hospitals and medical clinics, and colleges to support individuals who have Serious Mental Illness (SMI) and frequently use emergency and community services. RISE Community Service Coordinators are paired with law enforcement officers from several departments within Ventura County. These agencies include the Ventura, Simi Valley, and Oxnard police departments, as well as the Sheriff's office, which covers the cities of Thousand Oaks and Camarillo. Unlike traditional co-responder models, which respond to crisis calls, the RISE LE carries a caseload of individuals who consistently use emergency services. The RISE LE partnership team typically receives its referrals from law enforcement officers, with the goal of providing support and resources to its clients before the individual reaches a crisis event. Providing support, engagement and referrals to

ongoing services reduce calls to service providers and reduce incarceration and hospitalization. These services are needed for successful treatment and recovery.

RISE staff also partner with our Health Care Agency, in Backpack Medicine and One Stops – providing an opportunity to connect with our most vulnerable community members needing linkage to behavioral health services and other much needed resources. The RISE team continues to address the community issues mentioned above and has expanded this year to build relationships with local hospital emergency rooms to help unhoused clients link to services. The RISE team is engaged in additional training to identify and meet the unique needs of our unhoused community members.

Include examples of notable community impact.

RISE's flexible approach and problem-solving skills enable the team to respond to each unique case and truly meet clients where they are at. RISE engagement frequently results in connecting and supporting clients that are otherwise unresponsive or unengaged in services. RISE provides a lifeline to treatment teams that do not have the capacity to outreach clients when they disengage from services and treatment. Especially among the SMI population, when clients disengage from treatment, they often end up in a crisis episode and need support to reengage with treatment. RISE is able to intervene before client's reach a crisis point, preventing hospitalizations and LE interactions.

Success story.

After seven long months, RISE recently closed a case due to a client successfully completing three months of in-patient treatment. The client was struggling with suicidal ideation and substance use, and was a high utilizer of local emergency rooms, 911, and the crisis team. The client was connected with treatment but for multiple reasons, had difficulty remaining in treatment programs. With the support of RISE, the LE community and the client’s partner, the client was admitted to a treatment facility. The client is now able to remain engaged in treatment.

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

General System Development (GSD) is a category under CSS that funds programs and services that support and improve the existing health service delivery system designed for all clients and, when appropriate, their families (including those qualifying for Full-Service Partnership programs and especially target populations). Additionally, a constant and concerted effort is always made to improve and transform systems of care focused on clients and families. Funds under GSD may be used to fund the following:

- Mental health treatment, including alternative and culturally specific treatments
- Peer support
- Supportive services to assist clients and, when appropriate, their family members, in obtaining employment, housing, and/or education
- Wellness centers
- Personal service coordination/case management to assist clients (and when appropriate their families), to access needed medical, educational, social, vocational, rehabilitative, or other community services
- Individual needs assessment
- Individual Services and Supports Plan development
- Crisis intervention/stabilization services
- Family education services

While these funds are focused on being used to improve the County mental health service delivery system for all clients and their families, they can also be applied to collaborate with other non-mental health community programs and/or services and develop and implement strategies for reducing ethnic/racial disparities.

These programs are designed to promote interagency and community collaboration, and develop values-driven, evidence-based, and promising clinical practices to support populations with mental illness.

Subsequent sections describe the County GSD programming structure by categorizing specific programs under the following GSD subcategories:

- Crisis Intervention and Stabilization
- Individual Needs Assessment
- Treatment (non-FSP)
- Peer Support
- Peer Services Coordination and Case Management
- Client Transportation Program
- Forensic Pre-Admit/Mental Health Diversion Grant Program
- Linguistics Competence Services

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

GSD Programs Target Goals for Fiscal Year 2024-2025

Program	Target Served	Projected cost per client
Access Program (Access Line)	1,100	$1,943
Adult Short Term Treatment Team	2,200	$1,089
Adult Wellness Recovery Center and Mobile Wellness	850	$1,630
Arts and Wellness Creativity though the Arts (planning phase)	150	N/A
Candella Peer Support and Workshops	100	$924
County-Wide Crisis Team (CT)	980	$4,649
Crisis Residential Treatment (CRT)	380	$11,695
Crisis Stabilization Unit (CSU) Children's	260	$15,176
Family Access Support Team (FAST)	200	$4,856
Fillmore Community Project	190	$4,017
Forensic Pre-Admit	135	$2,784
Growing Works	35	$13,041
Housing	170	N/A
Mental Health Diversion Grant Program	90	$6,483
MESA Independent Living Support Services	40	$787
Mobile Crisis Outreach for Transitional Age Youth (MCOT)	120	$4,490
Mobile Response Team (MRT) for youth and families	25	$48,035
Moorpark EPSDT Services (planning phase)	N/A	N/A
Nates Place Wellness Center	100	$840
Semillas Planting Seeds of Wellness (planning phase)	30	N/A
TAY Wellness Center	160	$4,376
The Client Network	60	N/A
Transitional Age Youth (TAY) Outpatient Treatment Program	680	$1,029
VCBH Adult Outpatient Treatment Program	5,400	$5,183
Youth and Family Enhanced Care Management	20	$6,478
Youth and Family Intake Team	865	$1,356

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Program Demographics - Unduplicated Clients

Age Group	**N = 10,814**	
0 - 15 yrs.	1,087	10.05%
16 - 25 yrs.	2,033	18.80%
26 - 59 yrs.	5,994	55.43%
60 yrs & Older	1,700	15.72%
Gender Identity	**N = 9,469**	
Female	5,111	53.98%
Male	4,298	45.39%
Female-to-Male (FTM)/Transgender Male/Trans Man	17	0.18%
Male-to-Female (MTF)/Transgender Female/Trans Woman	17	0.18%
Non-Binary	8	0.08%
Other	7	0.07%
Transgender	11	0.12%
Race	**N = 7,988**	
White/Caucasian	3,943	49.36%
Black/African American	288	3.61%
Asian	150	1.88%
Native Hawaiian or Other Pacific Islander	18	0.23%
Alaska Native or Native American	66	0.83%
Other	3,521	44.08%
More Than One Race	2	0.03%
Sexual Orientation	**N = 1,011**	
Bisexual	47	4.65%
Declined to state	12	1.19%
Gay (male)	4	0.40%
Heterosexual / Straight	922	91.20%
Lesbian (female)	7	0.69%
Transgender	12	1.19%
Unsure / Questioning	1	0.10%
Prefer not to answer	6	0.59%
Ethnicity	**N = 7,675**	
Hispanic	4,190	54.59%
Non-Hispanic	3,484	45.39%
More Than One Ethnicity	1	0.01%

Program Demographics - Unduplicated Clients, con't.

Language Spoken	**N = 9,527**	
American Sign Language (ASL)	13	0.14%
Arabic	6	0.06%
Cambodian	1	0.01%
Cantonese	2	0.02%
English	8,366	87.81%
Farsi	6	0.06%
Japanese	1	0.01%
Korean	1	0.01%
Lao	1	0.01%
Mixteco	2	0.02%
Other non-English	19	0.20%
Portuguese	1	0.01%
Russian	5	0.05%
Spanish	1,080	11.34%
Tagalog	7	0.07%
Thai	3	0.03%
Vietnamese	13	0.14%
Military Serviced	**N = 846**	
Yes	7	0.83%
No	839	99.17%
Disabilities	**Not Collected**	

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development

County-Wide Crisis Team

Program Demographics

FY23-24 Program Cost	$ 3,498,528	
Total Individuals Served	981	
Cost Per Individual:	$ 3,566	
Individuals Served FY 22-23	2,111	
Age Group	**N = 981**	
0 - 15 yrs.	91	9.28%
16 - 25 yrs.	212	21.61%
26 - 59 yrs.	545	55.56%
60 & Older	133	13.56%
Gender Identity	**N = 672**	
Female	375	55.80%
Male	293	43.60%
Transgender man	3	0.45%
Other	1	0.15%
Race	**N = 487**	
White/Caucasian	220	45.17%
Black/African American	18	3.70%
Asian	13	2.67%
Native Hawaiian or Other Pacific Islander	3	0.62%
Alaska Native or Native American	3	0.62%
Other	230	47.23%
Sexual Orientation	**N = 78**	
Lesbian or Gay	1	1.28%
Heterosexual / Straight	72	92.31%
Other	3	3.85%
Declined to Answer	2	2.56%
Ethnicity	**N = 491**	
Hispanic	230	46.84%
Non-Hispanic	261	53.16%
Language Spoken	**N = 656**	
English	609	92.84%
Spanish	45	6.86%
Russian	2	0.30%
Veteran	**N = 79**	
Yes	1	1.27%
No	78	98.73%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The Crisis Team serves individuals of all ages who are experiencing a behavioral health crisis including those dealing with suicidal ideation, mental illness, or substance use. Last fiscal year, the team continued to promote the offerings of mobile crisis services, informing the community how they could access assistance. The program is ensuring to follow DHCS guidelines in delivering the Mobile Crisis Benefit, responding to behavioral health crisis in the field, within 60 minutes. The mobile crisis service team responds with a staff member who speaks the preferred language of the individual or family in crisis. If a bilingual staff member is not available, the team has access to an interpreter to provide the needed support. When providing community presentations, staff conduct the meeting in the preferred language of the target audience. Because there is a continued challenge of filling vacant positions, the team continues to focus on recruitment.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The Crisis Team continues to provide presentations throughout the community in the preferred language of the community receiving the presentation - providing information as to what services are provided, how/when to access our Mobile Crisis Services. Mobile Crisis Teams work closely with VCBH outpatient clinics to ensure a timely crisis response and follow up.

Include examples of notable community impact.

As the program continues to build up staffing, there are still sufficient staff to be able to be readily available to respond to behavioral health crisis in the community. A recent change to support this effort includes a dedicated Access team that takes the calls that come in, so that subsequent crisis team members are able to have a team ready to respond in the field.

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development

Crisis Residential Treatment (CRT)

Program Demographics

FY 23-24 Total Program Cost		**$ 4,650,414**
Total Individuals Served		386
Cost Per Individual:		$ 12,048
Individuals Served during FY 22-23		185
Age Group	**N = 386**	
16 - 25 yrs.	62	16.06%
26 - 59 yrs.	303	78.50%
60 yrs & Older	21	5.44%
Gender Identity`	**N = 362**	
Female	166	45.86%
Male	190	52.49%
Transgender woman	1	0.28%
Transgender man	3	0.83%
Non-Binary	1	0.28%
Other	1	0.28%
Race	**N = 343**	
White/Caucasian	167	48.69%
Black/African American	16	4.66%
Asian	5	1.46%
Native Hawaiian or Other Pacific Islander	1	0.29%
Alaska Native or Native American	3	0.87%
Other	151	44.02%
Sexual Orientation	**N = 76**	
Heterosexual / Straight	67	88.16%
Bisexual	5	6.58%
Other	2	2.63%
Declined to Answer	2	2.63%
Ethnicity	**N = 326**	
Hispanic	158	48.47%
Non-Hispanic	168	51.53%
Language Spoken	**N = 363**	
English	356	98.07%
Spanish	6	1.65%
American Sign Language (ASL)	1	0.28%
Veteran	**N = 52**	
No	52	100.00%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

Ventura CRT (VCRT) has an open-door policy and approach for all eligible clients within Ventura County. The program staff work closely with VCBH leadership, county clinics, Hillmont Psychiatric Center, and other partners in providing a pathway for admission such that gaps in treatment can be prevented. Treatment planning is based off the individual needs of each client and begins upon admission. To safeguard against any hidden biases, the staff work to identify those individual needs during the initial treatment planning and orientation process. This continues throughout placement. Another valuable source of feedback is from our weekly Client Council meetings. The treatment team takes special notice of clients who have a long history of homelessness, high utilizers of services, dually diagnosed, and younger clients. In order to address the significant challenge of clients leaving treatment early, the program has implemented a number of incentives to encourage all to remain in treatment until a safe “hand-off” can be accomplished. Another challenge noted this year was that there were more clients who struggled with basic self-care. To address this, the program implemented a daily hands-on life skills training where clients who struggle with this area of care are identified and staff will work with them directly on each given skill (bathing, basic hygiene, grooming, etc). Progress or lack thereof is reported back to the treatment team for evaluation.

Describe how this program addresses the community issues identified during the County’s Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

VCRT continues to take pride in being a partner with VCBH and the greater Ventura County community. This starts with our open-door policy (only limited by our regulations). In the daily "Flash Meetings", the treatment team discusses the client’s condition, progress towards skill acquisition, and steps made towards discharge planning. Over the past year, there has been a sizable increase in the number of justice-involved clients. At the time of this report, 12 of the 15 clients currently in placement are justice involved. Regarding this population, the staff work closely with the county case manager to provide behavioral and psychiatric updates, including concerns about those staff who feel they may leave placement.

In these instances, the program staff are truly thankful for this partnership. County case workers or clinical workers will collaborate with VCRT staff and even meet with the client in order to prevent them from leaving placement early.

Include examples of notable community impact.

While it remains difficult to quantify the exact impact of VCRT on the county, administration has noted improvements with regard to length of stay, meaning clients are staying in treatment longer and thus less likely to get rehospitalized. Program staff have worked with partners both within the jail and hospital system to streamline the referral and admission process in order to remove any unnecessary barriers towards placement.

Success story.

Another improvement the staff have worked with the County to accomplish is to admit conserved clients who are being discharged from a locked facility. This intermediate steppingstone allows staff to test out the client's ability to function within an open setting and work on skill acquisition. The program and clients have found this gradual step-down approach works extremely well in guiding the client towards more independence

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Crisis Stabilization Unit (CSU)

Program Demographics

FY 23-24 Total Program Cost		**$ 4,432,977**
Total Individuals Served		265
Cost Per Individual:		$ 16,728
Individuals Served during FY 22-23		284
Age Group	**N = 265**	
0 - 15 yrs.	102	38.49%
16 - 25 yrs.	163	61.51%
Gender Identity	**N = 246**	
Female	172	69.92%
Male	73	29.67%
Other	1	0.41%
Race	**N = 239**	
White/Caucasian	80	33.47%
Black/African American	6	2.51%
Asian	9	3.77%
Native Hawaiian or Other Pacific Islander	1	0.42%
Alaska Native or Native American	3	1.26%
Other	140	58.58%
Sexual Orientation	**N = 36**	
Heterosexual / Straight	35	97.22%
Bisexual	1	2.78%
Ethnicity	**N = 238**	
Hispanic	154	64.71%
Non-Hispanic	84	35.29%
Language Spoken	**N = 225**	
English	200	88.89%
Spanish	24	10.67%
American Sign Language (ASL)	1	0.44%
Veteran	**N = 161**	
No	161	100.00%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The Crisis Stabilization Unit (CSU) for youth is operated by Seneca and serves ages 6-17 who are experiencing a mental Health crisis. Youth who are placed on a civil commitment hold or who arrive on a voluntary status are assessed for appropriate level of care up to inpatient hospitalization. Should inpatient hospitalization be required, the CSU facilitates this transfer process. Youth who do not meet criteria are stabilized at the CSU and discharged following a psychiatrist assessment, safety planning process and aftercare meeting with the youth, their caregiver and other service providers. The long-term goal of CSU is to teach coping skills to youth and caregivers within a short period of time to alleviate the symptoms originally contributing to their CSU admission and engage in crisis management to divert or eliminate future hospitalization. The program provides services 24/7 and serves youth regardless of ability to pay and insurance status. They have access to bilingual Spanish and bicultural staff and a language line in order to provide services in the client's and family's preferred language. The CSU staff adhere to all required trauma informed practices, and complete required cultural competence training. The CSU continuously holds meetings with stakeholders to ensure that knowledge of the services is available and that any gaps in referrals are addressed. This year the CSU served 265 (unduplicated) youth with a diversion rate of 39% of clients returning to their families following CSU support. The CSU served 124 Hispanic youth, 56 Mexican American youth, 34 youth identifying as 2 or more ethnicities, 9 Filipino youth, and 4 Native American youth. In regard to preferred language needs: 4 monolingual Spanish youth and 1 youth requiring American Sign Language were served.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The CSU continues to meet quarterly with various community agencies to ensure that they are aware of this service available to youth, including law enforcement agencies. In fiscal year 23-24, law enforcement referred approximately 9% of the youth served at CSU, thus eliminating the need to go to the emergency room and receiving mental health

treatment more promptly. There has also been collaboration with local hospitals, ambulance companies and the Crisis team to mitigate potential unnecessary touchpoints for the youth who would benefit from CSU services, or to reduce barriers to engage in the appropriate level of treatment for those minors.

Include examples of notable community impact.

In the fiscal year 23-24, the CSU is faced with even more challenges related to lack of inpatient beds in the region. This has impacted on the ability to find appropriate placements for minors who may need a higher level of care. Regionally the CSU has experienced that there are less hospitals admitting youth under 10 and continue to struggle to place youth without insurance into inpatient psychiatric facilities. The CSU continues to work on a plan to mitigate these barriers and expedite connections to appropriate health care benefit options. Recently there has also been a noted increase in youth acuity. Despite these challenges the CSU had a diversion rate of 39%.

Success story.

'Emily' was referred to the CSU after she went through a breakup and the family dog passed away. These two losses were devastating, she reported feeling at her "lowest point" and feeling hopeless about her future. The CSU was her first admission to any sort of mental health support, and it provided a safe space for her to talk about the suicidal thoughts she was experiencing. Throughout her conversation with the clinician, they started to explore the difference between suicidal thoughts vs. intent, and mitigating factors to maintain safety. It was determined that she was not in imminent danger, and she was open to safety planning connecting to mental health services. She was receptive to continuing services with a therapist outside of the CSU and reported this would be helpful in navigating her emotions. The parents were also grateful as the CSU connected them with United Parents for further support and provided linkage to outpatient providers. Emily was safely discharged back to her parents' care without the need for inpatient hospitalization.

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Screening, Triage, Assessment and Referrals (STAR)

Program Demographics

FY 23-24 Total Program Cost	**$ 533,533**	
Total Individuals Served	2,060	
Cost Per Individual:	$ 259	
Individuals Served FY 22-23	3,497	
Age Group	**N = 2,060**	
0 - 15 yrs.	419	20.34%
16 - 25 yrs.	535	25.97%
26 - 59 yrs.	936	45.44%
60 yrs & Older	170	8.25%
Gender Identity	**N = 1,609**	
Female	916	57.00%
Male	691	43.00%
Race	**N = 1,025**	
White/Caucasian	508	49.56%
Black/African American	25	2.44%
Asian	10	0.98%
Native Hawaiian or Other Pacific Islander	2	0.20%
Alaska Native or Native American	9	0.88%
Other	471	45.95%
Sexual Orientation	**N = 134**	
Heterosexual / Straight	127	94.78%
Bisexual	3	2.24%
Declined to Answer	4	2.99%
Ethnicity	**N = 995**	
Hispanic	614	61.71%
Non-Hispanic	380	38.19%
More Than One Ethnicity	1	0.10%
Language Spoken	**N = 1,694**	
English	1,451	85.66%
Spanish	237	13.99%
American Sign Language (ASL)	2	0.12%
Tagalog	1	0.06%
Russian	1	0.06%
Farsi	1	0.06%
Other non-English	1	0.06%
Veteran	**N = 187**	
Yes	4	2.14%
No	183	97.86%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The Screening, Triage, Assessment and Referrals (STAR) program provides a link to appropriate mental health services and support in an efficient, high-quality, culturally sensitive manner county-wide. In cases where individuals do not qualify for specialty mental health services, they are referred to appropriate levels of care to fit their needs. The program continued to see an increase in the number of individuals seeking behavioral health services.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

STAR is the starting point for most individuals seeking behavioral health services. When the individual or family requests services, STAR staff works with them to determine their immediate needs. If they need support with appropriate linkage to resources, they are connected to our outreach teams RISE or Logrando Bienestar - that can provide extensive case management support. The goal is to reduce barriers to success and to connect clients with appropriate treatment providers. RISE plays a crucial role in connecting individuals that are unhoused to our STAR program to obtain the needed assessment to determine appropriate level of care and treatment.

Include examples of notable community impact.

As the program implemented the DHCS Standardized Screening Tool, a requirement of CalAIM, the staff was able to serve clients in a more streamlined and timely fashion in directing the individual to the appropriate delivery system. As the intake process has become streamlined with CalAIM the need to have a separate assessment team has diminished. As a result, the program ended mid-year of FY 2023-2024. In its place is Access Services provides screening and linking individuals/families in a very streamlined approach - to the appropriate level of care treatment provider to render service and complete a thorough assessment. This allowed for significant reduction of time, to get to their treatment provider.

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

VCBH Access Program

Program Demographics

FY 23-24 Total Program Cost		**$1,289,336**
Total Individuals Served		1116
Cost Per Individual:		$1,155
Individuals Served during FY 22-23		N/A
Age Group	**N = 1116**	
0 - 15 yrs.	236	21.15%
16 - 25 yrs.	245	21.95%
26 - 59 yrs.	552	49.46%
60 yrs & Older	83	7.44%
Gender Identity	**N = 738**	
Female	397	53.79%
Male	335	45.39%
Transgender woman	1	0.14%
Transgender man	1	0.14%
Transgender	1	0.14%
Non-Binary	3	0.41%
Race	**N = 520**	
White/Caucasian	255	49.04%
Black/African American	23	4.42%
Asian	7	1.35%
Native Hawaiian or Other Pacific Islander	1	0.19%
Alaska Native or Native American	5	0.96%
Other	229	44.04%
Sexual Orientation	**N = 92**	
Heterosexual / Straight	86	93.48%
Bisexual	4	4.35%
Declined to Answer	2	2.17%
Ethnicity	**N = 561**	
Hispanic	339	60.43%
Non-Hispanic	222	39.57%
Language Spoken	**N = 690**	
English	617	89.42%
Spanish	68	9.86%
Armenian	1	0.14%
Mixteco	1	0.14%
Thai	1	0.14%
Other non-English	2	0.29%
Veteran	**N = 116**	
No	116	100.00%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The Access program oversees the calls coming into the VCBH integrated Access/Crisis Line. The Access Team provides screening, triage, dispatch of mobile crisis services, linkage to appropriate mental health services and support in an efficient, high-quality, culturally sensitive manner county-wide. During the call the individual/family is given a DHCS Standardized Screening tool to determine if Special Mental Health services is the appropriate delivery system to provide care assessment. If so, they are provided with an appointment to a VCBH outpatient Clinic. If a lower level of delivery system of care is determined, then they are referred to the appropriate care provider to meet their needs. This approach has led to timelier results for adults and youth to receive care from the appropriate treatment provider because the required 7-domain assessment does not need to be completed prior to treatment. Unnecessary touch points have been reduced, and the program has continued to see and increase in the number of individuals seeing behavioral health services.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

As the Access program receives all calls coming into our integrated BH Access/Crisis Line and ensures that the individual or family that is calling in crisis receives immediate support. It is also the starting point for most individuals seeking behavioral health services. When the individual or family requests services, the Access team works with them to determine their immediate needs. If they need support with appropriate linkage to resources, they are connected to our outreach teams RISE or Logrando Bienestar - that can provide extensive case management support. The goal is to reduce barriers to successfully connect individuals/families with appropriate treatment providers.

Include examples of notable community impact.

As the program implemented the required CalAIM DHCS Standardized Screening Tool, our Access Team has been able to serve our community in a more streamlined and timely fashion.

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Adult Short Term Treatment Team (STT)

Client Counts per Clinic		
Conejo Valley Adult STT	345	15.00%
Oxnard Adult STT	508	22.09%
Santa Paula STT	47	2.04%
Simi Valley Adult STT	279	12.13%
South Oxnard Adult STT	484	21.04%
Ventura Adult STT	637	27.70%
Total Adult Outpatient Clients	2,226	100.00%

Program Demographics

FY 23-24 Total Program Cost	$ 1,652,285	
Total Individuals Served	2,226	
Cost Per Individual:	$ 742	
Age Group	**N = 2226**	
0 - 15 yrs.	2	0.09%
16 - 25 yrs.	232	10.42%
26 - 59 yrs.	1,680	75.47%
60 yrs & Older	312	14.02%
Gender Identity	**N = 1789**	
Female	933	52.15%
Male	843	47.12%
Female-to-Male (FTM)/Transgender Male/Trans Man	2	0.11%
Male-to-Female (MTF)/Transgender Female/Trans Woman	6	0.34%
Other	3	0.17%
Transgender	2	0.11%
Race	**N = 1247**	
White/Caucasian	632	50.68%
Black/African American	48	3.85%
Asian	26	2.09%
Native Hawaiian or Other Pacific Islander	3	0.24%
Alaska Native or Native American	11	0.88%
Other	527	42.26%

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

With the sunsetting of the STAR (Screening Triage Access and Referral) program, and the emphasis on NO WRONG DOOR and CAL-AIM initiatives, clients are able to directly access behavioral health services at the clinic of their choice utilizing Short Term Treatment (STT) programs. During this assessment process, clients are able to access services including assessment, medication services, groups, peer services, etc., thereby improving timely access for assessment and treatment and reducing confusion about how and where to access services. Clients can walk in without an appointment or call the access line to obtain the next available appointment.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

With the implementation of Short-Term Treatment, teams are trained to be able to determine the level of care and the types of services needed. Clients can be referred appropriately to behavioral health services either with VCBH clinics, the managed care plan or outside providers more suited to the client's needs. This has allowed clients to be more swiftly linked to behavioral health services, while still being provided with care as mentioned above and not getting lost or stuck in the system.

Include examples of notable community impact.

The implementation of Short-Term Treatment has allowed for more timely and efficient access to behavioral health services and a standard of care. For instance, a community member can walk into the clinic on Monday morning, request services, be assessed and see a doctor all within the same week (and sometimes within the same day). The client may either stay with the VCBH clinic or be referred to but will remain in the care of the team until they are successfully connected to their providers.

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Adult Short Term Treatment Team (STT)

Program Demographics, con't.

Sexual Orientation	N = 221	
Bisexual	8	3.62%
Gay (male)	1	0.45%
Heterosexual / Straight	202	91.40%
Lesbian (female)	1	0.45%
Transgender	4	1.81%
Declined to Answer	5	2.26%
Ethnicity	**N = 1,299**	
Hispanic	689	53.04%
Non-Hispanic	610	46.96%
Language Spoken	**N = 1,759**	
American Sign Language (ASL)	2	0.11%
English	1,573	89.43%
Japanese	1	0.06%
Lao	1	0.06%
Mixteco	1	0.06%
Other non-English	1	0.06%
Russian	1	0.06%
Spanish	176	10.01%
Tagalog	1	0.06%
Thai	1	0.06%
Vietnamese	1	0.06%
Veteran	**N = 254**	
Yes	3	1.18%
No	251	98.82%
Disability	**Not Collected**	

Success stories.

Some of the success stories for our short-term team were people who did not require long-term care and were able to be supported in the Short-Term treatment track. Oftentimes these were people who were frustrated, confused and unable to "navigate the system" without support and guidance. Team members were able to help clients apply for Medi Cal, EBT, Social Security and housing, providing them with the basic needs to be successful without long-term mental health treatment.

O.L. is a 40-year-old Vietnamese/American single female living with her two children (son 19, daughter 5) in Camarillo. She was tearful throughout her Peer Support sessions, indicating that she has been on an "emotional rollercoaster since last year". O.L. struggled with flashbacks, disturbances of emotions and feelings, nightmares and avoiding behavior regarding her previous traumas. She has had a history of emotional, physical and sexual abuse in childhood, as well as during adulthood. She reported severe anxiety and history of depressive mood since Junior High years and recent symptoms such as sadness, helplessness, worthlessness feelings, insomnia. O.L. has had a history of passive suicidal ideations in the past. O.L. was assessed by our Short-Term Treatment Team and the team explored what clinical resources could be provided to assist the client to stabilize. Medication services assessment, Peer Support Services, groups to address relaxation and trauma were recommended. The Short-Term Treatment Team also recommended community resources through Interface, and the Coalition for Family Harmony for additional resources as well. The process of the Short-Term Treatment Team model allows for continuous assessment of the client's progress and needs. In this case, staff determined that additional support was needed through Long Term Treatment model, but because support was initiated early in Short-Term Treatment, the client was able to stabilize more quickly and was transitioned into care in the community.

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Youth and Family Intake Team

Program Demographics

FY 23-24 Total Program Cost		**$ 416,170**
Total Individuals Served		879
Cost Per Individual:		$473
Individuals Served during FY 22-23		N/A
Age Group	**N = 879**	
0 - 15 yrs.	595	67.69%
16 - 25 yrs.	284	32.31%
Gender Identity	**N = 600**	
Female	341	56.83%
Male	254	42.33%
Non-Binary	1	0.17%
Transgender	4	0.67%
Race	**N = 458**	
White/Caucasian	198	43.23%
Black/African American	18	3.93%
Asian	5	1.09%
Native Hawaiian or Other Pacific Islander	2	0.44%
Alaska Native or Native American	4	0.87%
Other	231	50.44%
Sexual Orientation	**N = 30**	
Heterosexual / Straight	29	96.67%
Lesbian (female)	1	3.33%
Ethnicity	**N = 465**	
Hispanic	379	81.51%
Non-Hispanic	85	18.28%
More Than One Ethnicity	1	0.22%
Language Spoken	**N = 718**	
American Sign Language (ASL)	1	0.14%
English	546	76.04%
Mixteco	1	0.14%
Other non-English	5	0.70%
Spanish	165	22.98%
Veteran	**N = 157**	
No	157	100.00%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The Youth and Family Intake Team and Clinic programs are dedicated to serving underserved, moderate to severe youth populations, providing comprehensive services to individuals from birth through age 21. The team's commitment to cultural competency and linguistic accessibility is paramount. Services are offered in English, Spanish, Farsi, Tagalog, and Hindi. For other languages, utilization of certified interpreters or language line services, prioritizing in person interpretation whenever possible. This multifaceted approach ensures that staff effectively understand and address the unique needs of each client and family. The Youth and Family Service Intake Team and Clinic programs actively identify and mitigate barriers to care coordination. Through ongoing education and support, strive to empower clients and their families, fostering a sense of collaboration and trust. A significant portion of the caseload comprises foster and adopted youth and their families, who often require specialized family therapy and intensive care coordination involving internal and external stakeholders. To maintain high standards of care, staff participate in regular training and discussions focused on addressing barriers and disparities. Cultural considerations are a key component of our treatment team meetings, prompting a shared understanding and learning environment where we actively seek to understand and respond to the specific needs of our diverse clientele. This ensures equitable access to care.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

Conejo Valley

As a community mental health clinic, all clients have access to and utilize our services regardless of barriers such as language, legal status, and involvement with the justice system. The Conejo Youth and Family Intake Team's goals are to provide outpatient mental health services for youth impacted by moderate to severe mentally illness, improve functioning in the community, and reduce barriers to accessing care for all of those seeking services. Additionally, clinic staff partner regularly with community-based organizations, probation, school districts, primary care, and other support agencies to coordinate client care and address unmet needs.

Fillmore

During Fiscal Year 2023-2024, the intake team has served 68 youth, with 47% of the youth have identified as Latinx/Latine. This number is likely significantly higher, however due to a change in the Electronic Health Record used, some data will still need to be updated as staff are learning new processes of data entry. This program serves the city of Fillmore and neighboring unincorporated communities, which are geographically isolated in the county, with high percentage of residents being either Medi-Cal beneficiaries or indigent. High percentage of population is comprised of farm workers and their families, who are often underserved or unserved. Staff work regularly with the local homeless shelter, as well as community organizations (school district, One Step A La Vez community center, Tri-Counties Regional Center, etc.) to help bridge the gap between services and community members.

North Oxnard

As a community mental health clinic, we want all clients to have the ability to have access to and utilize our services regardless of barriers such as language, unhoused status, or legal issues. The North Oxnard Youth & Family Intake and Outpatient Clinic services moderate to severe mentally ill youth in the North Oxnard and Camarillo areas. The program works collaboratively with the Youth and Family Full-Service Partnership Program to capture clients and their families to a higher level of care (if clinically appropriate) at the intake process. Through the assessment process, staff were able to link several clients and their families to a higher level of care services that can support them in accessing the community issues identified during the County's Community Program Planning Process (ie homelessness services, clients working with multiple agencies such as probation and Children Family Services). Additionally, our clinic team increased the number of mental health associates in the clinic to support linking families to these much-needed community resources which includes building the families natural community resources and agencies such as MICOP who work with the Mixteco populations.

Santa Paula

During Fiscal Year 2023-2024, the Intake team has served 126 youth, and 70% of the youth have identified as Latinx/Latine. This number is likely higher, however due to changes in the Electronic Health Record used, some data will still need to be updated as staff are learning new processes of data entry. This program serves the city of Santa Paula and neighboring communities, which are geographically isolated in our county, with high percentage of residents being either Medi-Cal beneficiaries or indigent. High percentage of population is comprised of farm workers and their families, who are often underserved or unserved. Staff work regularly with the local homeless shelter, as well as community organizations (school district, Latino Townhall, Poder Popular, Santa Paula Social Services Coalition, churches) to help bridge the gap between services and community members.

Simi Valley

The community mental health clinic is committed to ensuring equitable access to services for all clients regardless of potential barriers such as language, acculturation, sexual orientation, educational background, Socioeconomic status, legal involvement, or housing situation. The Simi Valley Youth and Family Outpatient Program focuses on providing comprehensive outpatient mental health services to Ventura County youth and families who are experiencing severe and persistent mental health challenges. Safety is a priority for staff who all act urgently when receiving a crisis call or notification and ensure follow up with families within 24 hours. While the clinic's census and caseloads are experiencing growth, staff are pleased to report positive outcomes resulting from collaborative efforts through integrated core practice models. The Mental Health Associate is an expert Care Coordinator, she expedites assessments and matches adjunctive community services to the specific needs of children and families. Additionally, collaborative family team meetings have significantly improved our ability to connect clients with essential support

services that were previously difficult to access. Dedicated staff actively collaborate with a wide range of community partners, including the regional center, Children's Hospital, crisis stabilization units, compass programs, law enforcement, legal professionals, primary care providers, schools, housing support teams and other agencies. This collaborative approach ensures comprehensive client care and facilitates the effective addressing of unmet needs.

Ventura

Youth and their families have the ability to have access to and utilize our services regardless of language, unhoused status, or legal issues. Overall, the clinic census numbers and caseloads remain consistent with increased referrals to other community resources that best meet the client's individual needs. Additionally, clinical staff work regularly with community partners, local schools, faith-based organizations, law enforcement, child welfare, primary care physicians, hospitals, managed care providers, public health, housing programs, tri counties, parent support services to coordinate care and address unmet needs of often complex and multi stressed children and families. Families meet with both a case manager and Clinician during the intake to quickly connect and access resources during the intake process. All case managers have been trained in connecting appropriate clients to housing, resources for

developmental issues, connecting to medical care and basic needs such as food, clothing, shelter and hygiene. In addition, staff have been able to identify specialized needs to provide specialty mental health resources and programs to meet the individualized needs of the youth and or family. The staff have been able to identify needs and refer to parenting support, refer to local agencies for youth at risk of being trafficked and substance use related resources to increase support to other family members with presenting mental health, developmental, or trauma related needs. We provide transportation as needed to appointments and linkage to transportation resources available in the community. Staff have partnered to meet youth at schools and in the community to address underserved clients.

Include examples of notable community impact.

Conejo Valley

Collaboration with the school team has fostered a impactful communication pathway including ongoing collaborative meetings to ensure Social-Emotional Wellness is being targeted in a uniform manner in between agencies and to ensure that no one "falls through cracks" in either system.

Fillmore

The treatment team has noted how frequent barriers to care and improvement in health for youth is the needs of their parents or caregivers, to support the whole family system. As noted above, the team regularly assesses the other psychosocial needs of not just the client, but other family members, and supports connecting the family to community resources to reduce or prevent homelessness, establishing safe and predictable food resources, help obtain educational and mental health services related to domestic violence and prevent abuse. The team also works with various other larger systems (Child and Family Services, Adult Protective Services, Probation, Tri-Counties Regional Center, Ventura County Office of Education and relevant school districts) to address complex challenges and needs of the family, in order to support the recovery of the youth. Additionally, having a team approach (including individual and family therapists, psychiatric providers, case manager) provides different treatment modalities that together have a higher success rate in youth, reducing their symptoms and improving functioning in their lives.

North Oxnard

The North Oxnard Youth and Families Outpatient Clinic served the second highest number of clients in the county. In order to keep up with this demand, our multidisciplinary team included the psychologist, clinicians, and

mental health associates began implementing intake orientations in both English and Spanish. This parent group allowed a space for parents to learn about topics such as roles and services of each provider, the process in receiving care, as well as psychoeducation on mental health and linkage to community resources. In addition, the clinic Provided

parent and youth groups on several topics such as Seeking Safety, CBT for Depression and Anxiety, Aggression Replacement Therapy. The notable community impact was that each group is comprised of a separate parent and youth group to learn skills as well as a field trip to a local community program so that the client and family can continue to learn and apply the skills they learned into their natural environment.

Santa Paula

All of clinicians and case manager in the program are fluent in Spanish language and are able to meet the linguistic need. The program does not have psychiatric providers that are fluent in Spanish, however, services prioritize in-person translation services to bridge this gap. The case manager (formally Mental Health Associate) provides extensive support to the families of the clients, in connecting with community organizations and resources, which has been essential in supporting stability of the family system and parent/caregiver ability to be emotionally and psychologically available to the youth as they complete their healing journey; these connections include help with accessing a local shelter and housing resources, food bank/distribution centers, MediCal and other Human Service Agency resources, Department of Rehabilitation and other employment support services for young adults, domestic violence resources, as well as support regarding immigration and asylum concerns. Ability for the clinicians to provide family therapy in Spanish supports the healing of the family system which in turn impacts the improvement of youth's mental health.

Simi Valley

The Simi Valley Youth and Family Intake Program and clinic has a proactive approach to supporting children and families in the community. The program established a robust partnership with our CIT trained police officers, working collaboratively to de-escalate crisis and prevent unnecessary hospitalizations or incarcerations. This involves early identification of young people at risk and the implementation of timely, effective interventions and support systems tailored to client's needs. Beyond the direct work with families, we are committed to enhancing the mental health awareness and skills of first responders. The staff have provided Mental Health First Aid training on 5 occasions this year, effectively equipping the community participants with knowledge and skills to effectively respond to a child in crisis. Staff have also provided 2 Youth Mental Health training courses for CIT first responders including role plays to enhance their hands on skills. Strong collaborative relationships are maintained with school teams in Simi Valley and Moorpark. The program staff are consistently striving to improve our collaborative efforts, aiming to ensure safety and develop comprehensive and readily available support for our community’s youth and for our school teams. Staff believe that this integrated approach significantly improves outcomes for children and families facing mental health challenges.

South Oxnard

Staff work closely with the agency and partners to provide a high level of care for the target population. Additional services include parent orientations and a boy’s youth group in the past. The program collaborates on a daily basis with the school district providing on-site mental health services for students identified as having severe emotional disturbance. If a consumer moves to cities, districts, or needs to change clinics treatment team members ensure there is as smooth transition as possible to ensure continuum of care.

Success stories.

Conejo Valley

EH was a youth that was using substances daily, running away from home, not attending school, and engaging in risk behaviors. Her clinician partnered with SUTS services to ensure continuity of care from both systems of care. She is now attending school consistently, achieving passing grades, no longer uses substances daily and no amphetamine use, and has stopped running away.

Fillmore

Client is a 12-year-old Latino, referred for services because client had an increase of tantrums, reactive aggression, would throw objects, have difficulty controlling emotions, poor attention and concentration, impulsive. The client's symptoms started after he had a traumatic/stressful encounter with a student from school that led to chronic fear of being harmed, and as a result would avoid the student and certain parts of the school and classes having difficulty sleeping and concentrating. Staff were able to quickly provide assessments and transfer to the treatment team, which leads to the client practicing his communication skills, implementing anger management techniques, and engaging in family therapy to address concerns at home and communicate with the parent. The family members explored new ways to resolve relational issues. Client's symptoms eventually subsided and client and parent the treatment goals were met. Per mother, client is getting along well with siblings, started to play on a football team, stopped yelling or throwing things when upset and able to more effectively communicate, became more affectionate with mother, and passed classes this past semester for school.

Simi Valley

This report summarizes the progress of an 18-year-old Latino male client diagnosed with Major Depressive Disorder and Generalized Anxiety Disorder. Initially referred from Kaiser Permanente to Ventura County Behavioral Health due to high acuity concerns including a severe trauma history and frequent suicidal ideation and gestures (e.g., threatening self harm at a highway overpass). The client presented with significant depressive symptoms: hopelessness, social isolation, impaired concentration, aggression, and excessive guilt. At the time of the referral, suicidal gestures occurred up to 3 times a week. He also experienced challenges in academics, interpersonal relationships, and family dynamics, sometimes manifesting as aggression. Following his agreement to weekly therapy and psychiatric support and collaboration with our local CIT police officers, client demonstrated consistent engagement and medication compliance. This resulted in substantial clinical improvement. Suicidal ideation ceased, and psychiatric medication is no longer required. Academic performance has dramatically improved; he is enrolled in Honors Classes, is on track for graduation, and has submitted applications to several colleges. Furthermore, the client has developed robust emotional regulation skills, gained insight into his trauma responses, and exhibits improved self-expression and confidence.

Ventura

A 15 year old youth referred to by his managed care plan after discharge from hospital due to concerns about psychosis symptoms and need for more intensive behavioral health support. Staff assessed youth post hospitalization, engaged in mental health services and engaged family members in collaborative sessions to better understand the changes occurring to youth and impact of stressors on youth functioning. The family was open to exploring psychosis symptoms and further assessment from the VCPOP- early psychosis program and is in the specialty program for early onset psychosis to meet individualized needs of the youth.

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Youth and Family Intake Team

A family that lived several months in Ventura and several months in Chile requested an assessment. Staff assessed the 8-year-old youth, engaged in assessment, determined youth would benefit from services and they had to leave for Chile for summer, staff told them to contact the clinic when they returned to re-connect to services. When they returned, they called, and staff re-engaged the family right away to address intense anxiety, increasing school and family functioning impacted by anxiety. The youth were able to improve functioning and decrease anxiety symptoms and increase confidence in utilizing supports built.

The rapid engagement team referred to a 16-year-old youth that is on probation, and didn't want to participate or engage in services for the past 6 months and was running away. The assessor was able to engage youth and after assessment youth reported she will only participate in services if she continues to work with assessor. The assessors have some designated room on their schedules for treatment cases and continuity of care when appropriate for need of assessed person. The youth continue to consistently engage in treatment at our community clinic to address presenting problems.

A Clinician was working with Latinx youth and family realized sibling may need to be assessed for treatment needs. The elementary school also referred the nine-year-old sister to treatment, who was impacted by older brother's anxiety symptoms, bullying, worries, physical symptoms related to worries and having difficulty sleeping. The team was able to assess the sibling at the time of request and assign her to her own specialty mental health support and after six months in treatment is ready to discharge due to increase in functioning at home and school.

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Fillmore Community Project

Program Demographics

FY 23-24 Total Program Cost	$ 607,125	
Total Individuals Served	194	
Cost Per Individual:	$ 3,129	
Individuals Served FY 22-23	188	
Age Group	**N = 194**	
0 - 15 yrs.	88	45.36%
16 - 25 yrs.	106	54.64%
Gender Identity	**N = 179**	
Female	100	55.87%
Male	79	44.13%
Race	**N = 166**	
White/Caucasian	78	46.99%
Black/African American	1	0.60%
Asian	1	0.60%
Alaska Native or Native American	2	1.20%
Other	84	50.60%
Sexual Orientation	**N = 13**	
Bisexual	2	15.38%
Heterosexual / Straight	10	76.92%
Declined to Answer	1	7.69%
Ethnicity	**N = 147**	
Hispanic	135	91.84%
Non-Hispanic	12	8.16%
Language Spoken	**N = 176**	
English	149	84.66%
Spanish	27	15.34%
Veteran	**N = 7**	
No	7	100.00%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable

The Fillmore Youth and Family Clinic team continues to serve clients in the city of Fillmore and neighboring rural communities. The clinic has experienced a continued growth in client census, serving 215 youth during Fiscal Year 2023-2024, an increase of 12% from the previous year. Data is indicating that 74% of youth have identified as Latinx/Latine, however, this may be related to change in the Electronic Health Record (EHR) utilized during this period, and data needing to be updated. Data also indicates that 60% (129) clients received case management/care coordination services, which appears to be a decrease from the previous year; this likely was impacted by the EHR change

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The program continues to collaborate with the local school district and other community organizations, to support community members being connected and provided behavioral health services. This community is considered underserved, as it is comprised of a high percentage of Medi-Cal beneficiaries and uninsured/underinsured individuals. Additionally, majority of the community is comprised of Latinx/Latine individuals, with Spanish being primary language spoken. Clinicians are all fluent in Spanish language and provide services accordingly. The clinic is in collaboration with the TAY-focused center (One Step A La Vez) also supports additional help to individuals to develop their positive social connections, job training and educational support, as well as cultural practices for a whole-person care approach.

Include examples of notable community impact.

One of the recommendations from the Specialized Focus Groups was addressing the difficulty of having a separate conversation about mental health from cultural stigma. Having the Fillmore clinic located in a non-descript County building (that also houses a medical clinic and social services) reduces that stigma. The second recommendation was the need for cultivating trust within community to address the barriers that prevent connection to mental health services. This program has addressed this by continued and regular meetings with various community organizations, by providing educational presentations to improve knowledge and understanding of specialty mental health services and discussing problem-solving barriers to accessing services and engaging in treatment. Lastly, the clinical staff provide continues psychoeducation to the youth and their families regarding trauma and its impact on mental health.

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Fillmore Community Project

Success story.

Client was an eighteen-year-old Latina, referred by a psychiatric hospital after she was treated there for 10 days. She and her family reported ongoing difficulties with symptoms of inattention and hyperactivity, depression, suicidal ideation, sense of constant anger and fatigue. She regularly isolated from family and peers and was failing her classes at school. Additionally, she was engaging in self-harm behaviors. The client was provided with individual and family therapy, case management and psychiatric services. Our team collaborated with her school team, as she was also receiving special education services. By the end of the treatment, she was able to have minimal symptoms, regularly socialized at home and with friends, stopped harming herself and graduated from high school. Our client obtained a job at a local ranch and was in the process of enrolling at a community college, at our termination of care. Her psychiatric services were transferred to her primary care clinic, for ongoing management of symptoms

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Transitional Age Youth Outpatient Treatment Program – Non-FSP

Program Demographics

FY 23-24 Total Program Cost		**$196,038**
Total Individuals Served		684
Cost Per Individual:		$ 287
Individuals Served during FY 22-23		577
Age Group	**N = 684**	
16 - 25 yrs.	649	94.88%
26 - 59 yrs.	35	5.12%
Gender Identity	**N = 621**	
Female	380	61.19%
Male	231	37.20%
Female-to-Male (FTM)/Transgender Male/Trans Man	4	0.64%
Male-to-Female (MTF)/Transgender Female/Trans Woman	4	0.64%
Other	1	0.16%
Transgender	1	0.16%
Race	**N = 534**	
White/Caucasian	209	39.14%
Black/African American	19	3.56%
Asian	7	1.31%
Alaska Native or Native American	6	1.12%
Other	293	54.87%
Sexual Orientation	**N = 66**	
Bisexual	11	16.67%
Gay (male)	2	3.03%
Heterosexual / Straight	50	75.76%
Transgender	3	4.55%
Ethnicity	**N = 489**	
Hispanic	347	70.96%
Non-Hispanic	142	29.04%
Language Spoken	**N = 625**	
American Sign Language (ASL)	2	0.32%
English	572	91.52%
Other non-English	1	0.16%
Spanish	49	7.84%
Vietnamese	1	0.16%
Veteran	**N = 28**	
No	28	100.00%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable

The Transitional Age Youth Outpatient Treatment (TAY) program strives to provide services to underserved populations in the 18-25 age range. TAY staff are available to provide services in both English and Spanish and a certified interpreter or language line services are used for other non-threshold languages. In person interpretation is always prioritized. This communication helps to provide comprehensive cultural and linguistic services, so the needs of the clients are better understood. It also identifies what the barriers are for care coordination and how to best support/educate clients and their families, so clients feel supported and heard. TAY staff regularly have training and discussions about disparities in care and how to bridge the gaps for the clients. Cultural considerations are regularly discussed in treatment team meetings so that all team members can gain an understanding and learn from clients and peers about what the need will be to participate in and access care. One of the challenges identified has been to increase TAY services across Ventura County and expand the service areas so that the most culturally and linguistically competent services are provided to the most impacted residents.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The TAY program works closely with the housing team to allow TAY clients access to the TAY Housing Grant to support clients who are homeless or at risk of becoming homeless, providing them with rental assistance, motel vouchers or basic needs. Staff work closely with the forensics department to support clients who are in the Mental Health Diversion program or Mental Health Court to engage clients in treatment services so that they can complete the programs successfully. The TAY program provides comprehensive mental health services to clients with multiple barriers, utilizing a lens of cultural humility, to move clients toward personal recovery by providing stabilization and skill development to live an independent and successful life within the community.

Include examples of notable community impact.

Having access to specialized TAY services throughout the County will help to reduce disparities within the organization and long-standing inequities of health care systems that have an impact on the most vulnerable communities. If TAY clients receive the necessary care, compassion, skill building and evidence-based practices, the number of clients who remain in specialty mental health care beyond this age group would be reduced. TAY staff work on helping clients have their basic needs met so that higher level needs can be addressed to support and help meet treatment goals.

Overall, TAY has had multiple discharges due to clients transitioning to a lower level of care after months of stability (i.e., no suicide attempts, psychiatric hospitalizations, or crisis contacts).

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

VCBH Adult Outpatient Treatment Program

Client Counts per Clinic		
Conejo Valley Adult MHS	991	17.80%
Oxnard Adult MHS	928	16.67%
Santa Paula MHS	667	11.98%
Simi Valley Adult MHS	795	14.28%
South Oxnard Adult MHS	1,175	21.11%
Ventura Adult MHS	1,011	18.16%

Program Demographics

FY 23-24 Total Program Cost	**$ 26,095,765**	
Total Individuals Served	5,442	
Cost Per Individual:	$ 4,795	
Individuals Served during FY 22-23	6,076	
Age Group	**N = 5,442**	
16 - 25 yrs.	271	4.98%
26 - 59 yrs.	3889	71.46%
60 yrs & Older	1282	23.56%
Gender Identity	**N = 5,290**	
Female	2817	53.25%
Male	2453	46.37%
Female-to-Male (FTM)/Transgender Male/Trans Man	7	0.13%
Male-to-Female (MTF)/Transgender Female/Trans Woman	8	0.15%
Non-Binary	3	0.06%
Other	1	0.02%
Transgender	1	0.02%
Race	**N = 4,927**	
White/Caucasian	2,504	50.82%
Black/African American	171	3.47%
Asian	103	2.09%
Native Hawaiian or Other Pacific Islander	15	0.30%
Alaska Native or Native American	44	0.89%
Other	2,088	42.38%
More Than One Race	2	0.04%

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The Adult Outpatient program strives to provide services to underserved populations who are 25 and beyond. Staff are available to provide services in both English and Spanish, and a certified interpreter or language line services are used for other non-threshold languages. In person interpretation is always prioritized. This communication helps to provide comprehensive cultural and linguistic services, so the needs of the clients are better understood. It also identifies what the barriers are for care coordination and how to best support/educate clients and their families, so clients feel supported and heard. Staff regularly have training and discussions about disparities in care and how to bridge the gaps for the clients. Cultural considerations are regularly discussed in treatment team meetings so that all team members can gain an understanding and learn from clients and peers about what the need will be to participate in and access care.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

As a community mental health clinic, all clients should have access to and utilize our services regardless of barriers such as language, unhoused status, or legal issues. The Conejo Adult Outpatient program's goals are to provide outpatient mental health services for the severe and persistent mentally ill population of Ventura County. Overall, the clinic census numbers and caseloads continue to increase, however, the Peer Support Specialist role was fully implemented and had a very positive impact on clinic-based services with the goal of reaching and connecting with vulnerable populations. Additionally, the clinic staff

Program Demographics, con't.

Sexual Orientation	N = 609	
Bisexual	26	4.27%
Gay (male)	1	0.16%
Heterosexual / Straight	565	92.78%
Lesbian (female)	3	0.49%
Prefer not to answer	5	0.82%
Transgender	2	0.33%
Unsure / Questioning	1	0.16%
Declined to Answer	6	0.99%
Ethnicity	**N = 4,652**	
Hispanic	2,317	49.81%
Non-Hispanic	2,335	50.19%
Language Spoken	**N = 5,283**	
American Sign Language (ASL)	7	0.13%
Arabic	6	0.11%
Cambodian	1	0.02%
Cantonese	2	0.04%
English	4,708	89.12%
Farsi	5	0.09%
Japanese	1	0.02%
Korean	1	0.02%
Lao	1	0.02%
Other non-English	12	0.23%
Portuguese	1	0.02%
Russian	2	0.04%
Spanish	519	9.82%
Tagalog	5	0.09%
Thai	1	0.02%
Vietnamese	11	0.21%
Veteran	**N = 289**	
Yes	1	0.35%
No	288	99.65%
Disability	**Not Collected**	

work regularly with community partners, law enforcement, attorneys, primary care, housing teams and other support agencies to coordinate client care and address unmet needs.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

Conejo Valley Mental Health Services

As community mental health clinics, we want all clients to have access to and utilize services regardless of barriers such as language, unhoused status, or legal issues. The Adult Outpatient program's goals are to provide outpatient mental health services for the severe and persistent mentally ill population of Ventura County. Overall, the clinic's census numbers and caseloads continue to increase, however, the Peer Support Specialist role was fully implemented and had a very positive impact on clinic-based services with the goal of reaching and connecting with vulnerable populations. Additionally, the clinical staff work regularly with community partners, law enforcement, attorneys, primary care, housing teams and other support agencies to coordinate client care and address unmet needs.

Include examples of notable community impact.

Conejo Valley Mental Health Services

The treatment team noted services that could improve utilizing existing resources. Although groups are offered, translation services were needed for some of the Spanish speaking consumers that attended. An Emotional Wellness Group for Women was implemented for those whose primary language is Spanish so that these clients could have equal opportunity to engage in group treatment services that also acknowledged not only their language needs but their cultural needs as well. Through this process, the clinical needs of multiple clients were met, they developed more effective emotion regulation skills, socialization skills, and support. In the continued effort to provide services to unserved or underserved populations, it was noted that many of our male consumers needed a setting to address issues related to them specifically. The Team created the Men's Wellness Group to provide them a safe place to explore their need for effective coping skills, decrease isolation, and increase engagement skills. Mental Health Associates (Case Managers) are an integral part of our Multidisciplinary Treatment Team.

They have made significant strides in identifying unhoused populations and are connecting them to resources in the community even though resources have dwindled in the East County/Conejo Valley area.

Oxnard Mental Health Services

With the implementation of Short-Term Treatment, the North Oxnard Clinic has experienced a more stable client population. As a result, the clinical needs of multiple clients were met, whether it was through individual psychotherapy, groups, or case management support. Caseloads have stabilized and allowed staff to focus on ensuring proper outreach and engagement with clients.

Santa Paula Mental Health Services

In fiscal year 23/24, the Short-Term Treatment Team was created to improve timely access to mental health services with a focus on unserved and underserved populations. The team handles all the screenings of new clients and provides scheduled appointments for assessments. To reduce any barriers to services, the clinic has scheduled walk-in hours so individuals and/or family members can bring in clients to the clinic and be seen by VCBH staff.

Simi Valley Mental Health Services

The program has increased collaborative efforts with the Simi Valley Police Department this year. Staff had plentiful interventions both in the clinic and in the field many times that included both SVPD and VCBH personnel.

South Oxnard Mental Health Services

With the implementation of Short-Term Treatment, the South Oxnard Clinic has experienced a more stable client population. As a result, the clinical needs of multiple clients were met, whether it was through individual psychotherapy, groups, or case management support. Caseloads have stabilized and allowed staff to focus on ensuring proper outreach and engagement with clients.

Ventura Mental Health Services

The recent addition of resident and addiction fellows to Ventura Outpatient clinic has significantly enhanced capacity to provide comprehensive care. The fellows' specialized expertise in various areas enriches the clinical team, allowing staff to offer a wider range of treatment options and evidence-based interventions. This collaborative approach also provides invaluable learning opportunities for the fellows, as they gain hands-on experience working with patients with severe mental illness, contributing to the development of future mental health professional and positively impacting the community.

Success stories.

Conejo Valley Mental Health Services

S.H., a 58-year-old male, faced several challenges throughout his life. The biggest challenges he has faced have been his long battle with major depression, chronic medical complications that are still ongoing, and his 15+ years of homelessness. Overwhelmed, he isolated himself from the outside world and was uncertain about his overall future. Despite these struggles, he continued to seek mental health support and did not give up hope.

During the COVID-19 pandemic, our most vulnerable homeless population was housed through an emergency housing project. During this time, S.H. began to slowly engage with our mental health professionals by participating in treatment with our clinic. Through therapy, seeing his psychiatrist for medication support, case management, and the guidance of our care team, he began to address his mental health issues and began to embark on a journey of healing and self-discovery. He utilized his resources with our clinic and ultimately was presented a housing opportunity in the community. While working with his case manager, S.H. dedicated himself to making a positive change in his life and began taking action to reclaim his life once again. Over time, S.H not only rediscovered stability, but also found purpose to continue to fight for what he believes in. To this day, he continues to help others who also face mental health challenges and dedicates his time to helping those who are also facing homelessness by sharing his experiences and providing resources in the community which have guided him to wellness. His journey is a testament to the profound impact of community, compassion, and determination. His story reminds us that even in the darkest moments of our lives, transformation is possible through perseverance and surrounding oneself with the right support systems.

Oxnard Mental Health Services

N.R. is a 54-year-old Latina client. She was initially referred to VCBH due to depressive symptoms after a work injury left her disabled. Experiencing multiple historical suicide attempts (i.e. walking into the ocean and overdosing on Xanax), the client has also had historical passive SI (i.e. thoughts of overdosing, cutting her wrists, and jumping in traffic). Having previously acted on passive SI with cutting behaviors, she also isolated herself, which further contributed towards her acting on passive SI and cutting behavior.

This client was connected to VCBH clinical staff for medication management and individual therapy. After working with clinical staff, she has remained compliant with medication instructions and felt capable of being transitioned to a lower level of care. The result has been that she has not been hospitalized for three years and refrains from cutting behavior, despite periods of heightened depression. She is able to use coping skills acquired in our program and plans on revisiting individual therapy to continue expanding her coping skills. The client is connected to friends and family and is no longer isolated. She is thankful to VCBH staff for the support given to her and has relayed that she would not be alive today without the assistance of this team.

Santa Paula Mental Health Services

Client A.P. presented with depressive moods such as sadness, sense of hopelessness and loneliness, low motivation, eating too much and sleeping more than normal and self-isolation. This was accompanied by rushing thoughts, verbosity, risky behaviors, shoplifting, irritability and anger. These behaviors led to multiple incarcerations.

After we admitted this client to our inpatient hospital unit, he stabilized with medication. He continues to participate in outpatient treatment, has maintained full time employment and is about to graduate from barber school.

South Oxnard Mental Health Services

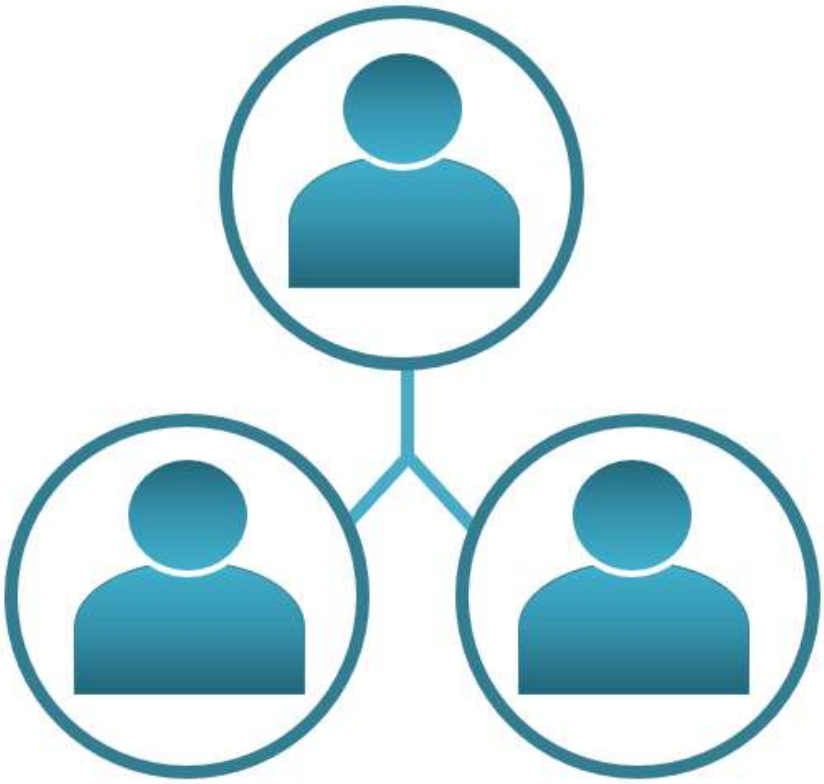
E. B. is a 31-year-old Spanish speaking Latina client. She had been an active client for the past 4 years who participated in individual psychotherapy and groups. She attended the Spanish speaking group "Salud, Bienestar y Relajacion". She made significant progress recently and asked to be discharged from the outpatient clinic as she exhibited significant recovery. She is now a business owner with her husband and an active member in her church community. She volunteers at her children's school.

Ventura Mental Health Services

R. K. was an unhoused substance user who had lost his relationship with son and his son's mother. He was walking into traffic and if not actually walking in traffic he was thinking about it. He was inconsistent with appointments and medications. He was accepted at Mercy House, started being consistent with his medications, got his benefits started and finally got an apartment of his own! He has repaired the relationship with his son's mother, and he sees his son on a regular basis. R.K. looks and acts like a brand-new person.

COMMUNITY SERVICES AND SUPPORTS (CSS)

The following section reports on programs within General System Development (GSD) that utilize peers to provide services to clients.



COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

The Client Network

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The Client Network is a peer-run advocacy organization with a client-centered approach to mental health recovery. The Client Network promotes hope, respect, personal empowerment, and self-determination. It advocates for clients to become full partners in their unique treatment and recovery journeys. Certified peer support specialists provide one-on-one peer support, resources, and referrals. The Client Network promotes measures that counteract stigma and discrimination against mental health consumers by increasing representation, involvement, and empowerment at all levels of the mental health system where client voices have traditionally not been heard. The Client Network collaborates with community partners on client outreach and engagement and hosts numerous holiday events throughout the year. Members sit on the Behavioral Health Advisory Board and its subcommittees. As part of the Mental Health Services Act (MHSA) Community Programming Planning (CPP) process, the Client Network actively contributes to shaping mental health policy and programming through the stakeholder process at the county and departmental levels. Client Network members collaborate with Ventura County Behavioral Health (VCBH) and the Behavioral Health Advisory Board (BHAB) during the three-year strategic planning process, the annual EQRO, and ongoing QIC efforts.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc. examples of notable community impact.

Services were recently expanded with the addition of a Medi-Cal Certified Peer Support Specialist. The program is now offering onsite peer support at Villa Calleguas for its residents, which includes crisis assistance, groups, events, and socialization opportunities. The Client Network continues its outreach and peer support to the underserved population who are residents at county Board and Cares, Adult Residential Care Facilities (ARF), Residential Care Facilities for the Elderly (RCFE), as well as unhoused individuals.

	Name of meetings Peers attended during the year (list not comprehensive):
Example of the meetings the Peers attended for the year:	
	Behavioral Health Advisory Board – General
	Behavioral Health Advisory Board – Executive Committee, Vice Chair
	Behavioral Health Advisory Board – Adult Services Committee
	Behavioral Health Advisory Board – Prevention Committee
	Behavioral Health Advisory Board – Ombudsman Workgroup, Chair
	Behavioral Health Advisory Board – Data Notebook, Coordinator
	Ventura County Board of Supervisors Meeting
	VCBH QMAC Meeting
	VCBH QI Community Experience Subcommittee Meeting
	California Association of Local Behavioral Health Boards and Commissions Training
	Suicide Prevention Council Meeting
	Peer Leadership Collaboratives Copeland Center
	California Association of Mental Health Peer-Run Organizations - Peer Leadership Committee
	VCBH Peer Workgroup
	Mental Health Services Oversight & Accountability Commission Meeting
	Cal Voices CARE ACT Workgroup
	Cal Voices Internal Policy Meeting
	Cal Voices MHSA Modernization SB 326 Committee Meeting
	MHSOAC Commission Meeting
	VCBH/MHSA Innovations Planning Committee Meeting
	VCBH/MHSA Strategic Planning Meeting

	Date	Event	Number of Residents
Peer Support Events	December 2023	Client Network Holiday Event	40
	May 2024	May is Mental Health Awareness Month Client Network Fiesta	70
		Advocacy Events	147
		Peer Support 1:1 Sessions	253
		Bus Passes	3,970
		Gift Cards	110

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

The Client Network

Please indicate how much you disagree or agree with the following statements:	% Agree
	(N = 170-174)
Staff were sensitive to my cultural background (e.g., ethnic/religious beliefs).	97%
Services were available in my preferred language.	98%
I was able to get connected to the services I thought I needed.	95%
Overall, I am satisfied with the services I received.	97%
I would recommend these services to a friend or family member.	93%
As a result of participating in this program:	% Agree
	(N = 170-173)
I am happier with the friendships I have.	87%
I have people with whom I can do enjoyable things.	85%
I do better in social situations.	80%
My housing situation has improved.	91%
I feel like I belong in my community.	83%
I feel better about myself.	82%
I am better able to handle things when they go wrong.	77%

This program distributes satisfaction surveys twice yearly for a duration of one month each time. These Client Perception and Satisfaction Survey results are shown below.

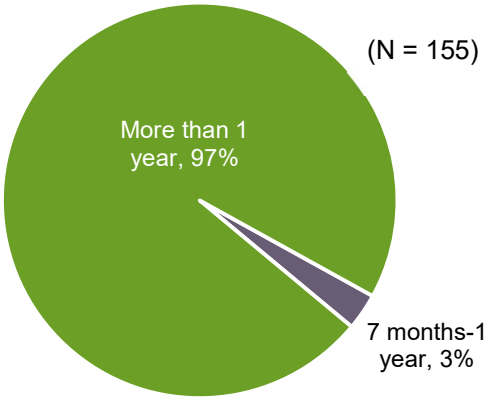
Most useful or helpful about this program: (n = 68)

- Socializing/friends
- Helps mentally
- Belongingness

Suggestions to make this program better: (N = 43)

- More activities
- More groups
- More days
- Already doing well – general

How long have you been participating in services?



COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Family Access and Support Team (FAST)

Program Demographics

FY 23-24 Total Program Cost		**$ 971,548**
Total Individuals Served		205
Cost Per Individual:		$ 4,739
Individuals Served during FY 22-23		214
Age Group	**N = 205**	
0 - 15 yrs.	161	78.54%
16 - 25 yrs.	44	21.46%
Gender Identity	**N = 203**	
Female	110	54.19%
Male	93	45.81%
Race	**N = 167**	
White/Caucasian	12	50.00%
Black/African American	7	29.17%
Asian	2	8.33%
Other	3	12.50%
Sexual Orientation	**N = 93**	
Heterosexual / Straight	91	97.85%
Lesbian or Gay	1	1.08%
Bisexual	1	1.08%
Ethnicity	**N = 165**	
Hispanic	144	87.27%
Non-Hispanic	21	12.73%
Language Spoken	**N = 118**	
English	56	47.46%
Spanish	59	50.00%
Other non-english	3	2.54%
Veteran	**N = 114**	
Yes	2	1.75%
No	112	98.25%
Disability - Communication	**N = 16**	
Difficulty Seeing	4	19.05%
Difficulty Hearing, or having speech understood	5	23.81%
Learning Disability	6	28.57%
Developmental disability	1	4.76%
Disability - Mental (not SMI)	**N = 15**	
Physical/Mobility Disability	5	23.81%
Chronic Health Condition/Chronic pain	10	47.62%
Disability - Other	**N = 1**	
Heart/Thyroid	1	4.76%

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The program is designed to provide services to severely emotionally disturbed (SED) children, youth and their families who are also served by Ventura County Behavioral Health, and who are at high risk for hospitalization or out-of-home placement. It is intended to be one component of a larger system of care that will work collaboratively within a community of service provision, providing a family and purpose-driven system of support to children and families. The United Parents Family Access and Support Team (FAST) program is staffed solely with Parent Partners (Peer Support Specialists) who are parents or caregivers who have raised children with serious mental/emotional disorders. The Parent Partners receive specialized training to support others in similar situations. Parent Partners collaborate with the treatment team, providing intensive home-based services to families. They offer a menu of services to support the goals of the family and program including education, support, stabilization and promoting wellness and resiliency, inspiring hope, and encouraging advocacy. They respect the values and cultural, linguistic uniqueness of each community, practice authenticity, acknowledge the importance of cultural responsiveness and humility, and model techniques with both individual and group modalities to support parents in strength-based skill-building and increase knowledge regarding their child's mental health status. The program also addresses increasing knowledge regarding services and resources to assist in alleviating crises. The Parent Partners also facilitate monthly support groups in the community and via Zoom as an additional layer of support and resource sharing to those families who are receiving or will receive VCBH services. The Parent Partners also provide services and support for families of other County or community-based programs including Seneca Family of Agencies Children's Crisis Stabilization Unit/COMPA, VCBH Access and Outreach program, and Insights program through Probation.

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Fast Access and Support Team (FAST)

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

Many families do not have reliable transportation, access to the internet, or a private space to receive services, causing further interruption in care and support. The Parent Partners meet the families where they are, i.e. in a safe and convenient location. They bring electronic devices to help families without internet connection fill out necessary paperwork and forms to assist with their needs. Families who prefer not to meet in-person are able to meet Parent Partners via Zoom. Parent Partners continue to be flexible and creative in their outreach to support and engage families in any way possible.

In the prior fiscal year, the demand for services has greatly increased and the severity of the diagnoses, trauma, and need has also increased. Sixty-five percent of the clients served in Fiscal Year 2023-2024 were Hispanic and 69% of the Parent Partners are also Hispanic, allowing them to relate to and deeply connect culturally with the families they are serving. Staff who are stationed at satellite locations i.e. Insights/Probation, Access and Outreach, Seneca continue to meet the families where they are and assist with crisis intervention and provide a smooth connection to the resources they need. The Parent Partners at these locations are speak English and Spanish.

The agency continues to offer and conduct "refresher presentations" to ensure that all clinics have the most up to date information regarding our referral process and waiting list for services. The staff have been utilizing SmartCare and began billing Medi-Cal in January 2023 (2 of 9 PPs). In July 2024, all Parent Partners will be involved and will be billing Medi-Cal. All Parent Partners are working toward their Peer Certifications. There are now six Certified Peer Support Specialists and three who are scheduled for their exam. One is scheduled to retake the exam, and another will begin training in May 2024. Our program has continued to implement multiple support groups in-person in the community. In Fiscal Year 2022-2023, there are five support groups -- two Spanish speaking groups (Oxnard and Santa Paula), one bilingual group (Oxnard), and two English speaking groups (one in Oxnard for fathers only) and one online group. Most of the attendees live in a high-need, unserved/underserved area and are appreciative of this support and are asking for more frequent gatherings. The program provides meals and childcare for all the support groups.

Community Client Referrals

Program	Referrals
Seneca	164
Insights	9

Include examples of notable community impact.

The program continues to establish and provide services in underserved areas including Oxnard, Fillmore, Simi Valley, Ventura, Santa Paula, Ojai, and Piru. We have parent support groups that are open to anyone in the community and provide dinner and childcare to attract families, In October 2023, a new support group for families began for parents of justice-involved youth and who experience incarceration and attend court. This support group focuses on learning to navigate the juvenile justice system, connection, and resource support, as well as providing an opportunity for parents to build their natural support network. The program will also be opening a parent drop-in center later this year, where anyone in the community can come in and obtain information on community resources, flyers, receive support, and get connected to services.

Parent Partners connect families to the appropriate and necessary support including housing, rental assistance, food pantries, clothing vouchers, legal aid assistance, cash aid, government assistance and employment services. United Parents has an emergency fund established through fundraising and donations to help clients with temporary

assistance while waiting for long-term support. The emergency fund has helped families with rental assistance, utility payments and gift cards for clothing. This program distributes satisfaction surveys twice yearly for a duration of one month each time. These Client Perception and Satisfaction Survey results are shown below.

Please indicate how much you disagree or agree with the following statements:	% Agree
	(N = 94)
Staff were sensitive to my cultural background (e.g., ethnic/religious beliefs).	97%
Services were available in my preferred language.	100%
I was able to get connected to the services I thought I needed.	96%
Overall, I am satisfied with the services I received.	99%
I would recommend these services to a friend or family member.	100%
As a result of participating in this program:	% Agree
	(N = 94)
My child gets along better with family members.	70%
My child gets along better with friends and other people.	67%
My child is doing better in school.	68%
My child is better able to cope when things go wrong.	59%
My child is better able to do things he or she wants to do.	65%
I am aware of when I need to ask for help for my child.	87%
I know where to find help when my child is having a problem.	94%
I believe treatment can help people with mental illness lead normal lives.	95%
The parent partners are generally caring and sympathetic to people with mental illness.	98%

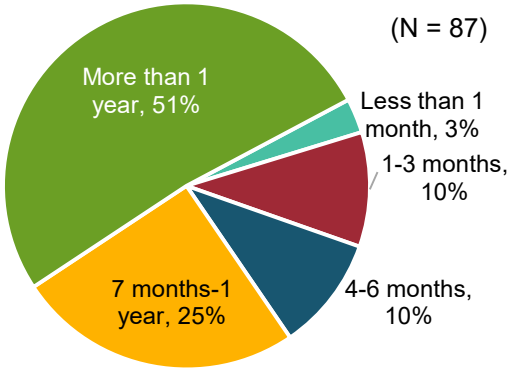
Most useful or helpful about this program: (N = 88)

- Parent Partners
- Support – general
- Resources/information
- Progress with my child

Suggestions to make this program better: (N = 65)

- Already doing well – general
- More time
- More staff/more trained people
- More services like this

How long have you been participating in services?



COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Fast Access and Support Team (FAST)

- The Healthy Families Parenting Inventory (HFPI) is designed to learn more about you as a parent and how you respond to different aspects of parenthood.
- We are interested in the kinds of changes you may have noticed in yourself since becoming a parent.
- This information is used to help design a plan to better serve you during your involvement with United Parents.
- *There are no right or wrong answers.*
- Questions are ordered in categories or subscales that help your Parent Partner identify areas of strengths and areas of concern.
- Each category has a baseline number. If the sum number of your responses in that category is above that baseline number, that indicates an area of strength.
- If the sum number falls below the baseline number, that indicates an area of concern that may require a more focused intervention.
- The FAST program is a short-term intervention; however, we realize that changes do take time.
- When looking over your results, it is important to note that you may not see big changes right away.
- This inventory is only a snapshot of your family dynamic, and it is normal to see both upward and downward shifts.
- If you have any questions or concerns with the information you see, please ask your Parent Partner for clarification.

Baseline and Responses from Active Clients in FY23-24

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Growing Works

Program Demographics

FY 23-24 Total Program Cost		$ 529,267
Total Individuals Served		35
Cost Per Individual:		$ 15,122
Individuals Served during FY 22-23		32
Age Group	**N = 35**	
16 - 25 yrs.	2	5.71%
26 - 59 yrs.	31	88.57%
60 yrs & Older	2	5.71%
Gender Identity	**N = 35**	
Female	6	17.14%
Male	29	82.86%
Race	**N = 33**	
White/Caucasian	19	57.58%
Black/African American	1	3.03%
Other	13	39.39%
Sexual Orientation	**N = 5**	
Heterosexual / Straight	5	100.00%
Ethnicity	**N = 32**	
Hispanic	16	50.00%
Non-Hispanic	16	50.00%
Language Spoken	**N = 35**	
English	33	94.29%
Spanish	2	5.71%
Veteran	**N = 2**	
No	2	100.00%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

Growing Works served 35 adults with diverse psychiatric diagnoses in 2023-2024. The most common were schizophrenic or schizoaffective disorders. Other diagnoses included personality disorders, eating disorders, anxiety, obsessive compulsive disorder and substance abuse.

The demographics consists primarily of Latinos and males, though the program accepts all gender identities and ethnicities. In the last year, the program recruited two Latinx staff members and one male staff member. This has increased awareness of cultural issues, set a new standard of inclusivity, and put representatives of underrepresented communities as leaders for our membership. To increase recognition and inclusion of our Latinx membership we are incorporating Mexican food into our celebrations.

The staff are working with a MSW intern to do some educational seminars on LGBTQ+ issues and sensitivity. In the last year at least two individuals identified themselves as LGBTQ+.

In the last two years, the change to Smart Care with extremely consuming training, a lack of charting goals, unknown compensation rates, and seemingly constant changes have been very trying.

Staff now submit the following on a regular basis:

• MORS	• Training Records (and training courses to support them)
• Client Self-Assessments	• Bi-monthly or so Contract Provider Meetings
• Staff Assessments	• Quarterly Provider Meetings
• Monthly Grievance Forms	• Data Tool Documentation

The program also operates a $250,000+ sales/year specialized nursery business with a total of 6 staff. The small team is constantly short-handed and trying to find ways to work smarter, not harder, and have a good work/life balance. Members, Supported Employees and Staff are feeling the effects of inflation individually and corporately: we have heard reports of rent increases, inflated gas prices, utilities, and food costs. Nursery supply costs have also increased significantly – some over 200% in the last two years.

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Growing Works

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

Most of Growing Works' clients are Full-Service Partnership clients – many have never held jobs, have experienced homelessness, have experience in the justice system, and have not held steady employment for years.

Volunteers, called Members, must complete 108 hours of volunteer service, the Wellness Recovery Action Plan, and a job skills class to become eligible for one of nine supported employment positions.

Members and Supported Employees work on their recovery by practicing coping skills as they participate in nursery functions including watering, transplanting, order pulling and preparation, taking inventory, and making deliveries.

Staff have worked strategically and carefully to create a stigma-free environment which is safe in every way. The clients find a new home where they can try new tasks, develop skills, explore their personalities and gifts, and be seen as valuable and contributing members of the community and business. Together everyone celebrates milestones– beating sales goals, promotions, holidays, etc. These are Growing Works community events where everyone enjoys the celebration because everyone has contributed. Staff are very aware of the extensive suffering the members have endured; a significant part of the program mission is to celebrate and nurture all the successes people experience at Growing Works. This creates a new foundation for self-esteem to help launch clients into new educational and employment opportunities.

Since Growing Works' inception in 2018, over 300 adults have participated in the program. Over 60 have moved on to competitive employment, 12 have pursued education, and 7 have been hired by the Turning Point Foundation. The most recent Turning Point hire was one of the supported employment employees. This woman came to Growing Works immediately after an inpatient experience. A single mom of three, she diligently pursued her requirements for supportive employment, while managing another job and personal responsibilities. Staff recommended her without reservation for a Peer Employment Specialist position at The Wellness Center in Oxnard. Growing Works is thrilled that she's thriving and drawing upon her lived experience to help others in their recovery.

Include examples of notable community impact.

Growing Works is a non-profit wholesale plant nursery and mental health recovery/job preparedness program of Turning Point Foundation. Volunteers, called Members, must complete 108 hours of volunteer service, the Wellness Recovery Action Plan, and a job skills class to become eligible for one of nine supported employment positions.

Members and Supported Employees work on their recovery by practicing coping skills as they participate in nursery functions including watering, transplanting, order pulling and preparation, taking inventory, and making deliveries.

Growing Works provides a purposely safe, stigma-free environment where everyone shares in victories. We are proud of our individual approach and ability to develop our members' skills and strengths.

Growing Works served 50 adults for Fiscal Year 2023-2024; for Fiscal Year 2024-2025 and have already served over 50 adults in the first six months. The program anticipates serving 95-115 adults in total in FY 2024-2025.

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Growing Works

This program distributes satisfaction surveys twice yearly for a duration of one month each time. These Client

Please indicate how much you disagree or agree with the following statements:	% Agree
	(N = 28-32)
Staff were sensitive to my cultural background (e.g., ethnic/religious beliefs).	82%
Services were available in my preferred language.	97%
I was able to get connected to the services I thought I needed.	87%
Overall, I am satisfied with the services I received.	94%
I would recommend these services to a friend or family member.	97%
As a result of participating in this program:	% Agree
	(N = 30-32)
I am happier with the friendships I have.	81%
I have people with whom I can do enjoyable things.	88%
I do better in social situations.	74%
My housing situation has improved.	47%
I feel like I belong in my community.	65%
I feel better about myself.	81%
I am better able to handle things when they go wrong.	68%

Perception and Satisfaction Survey results are shown below.

Most useful or helpful about this program: (N=29)

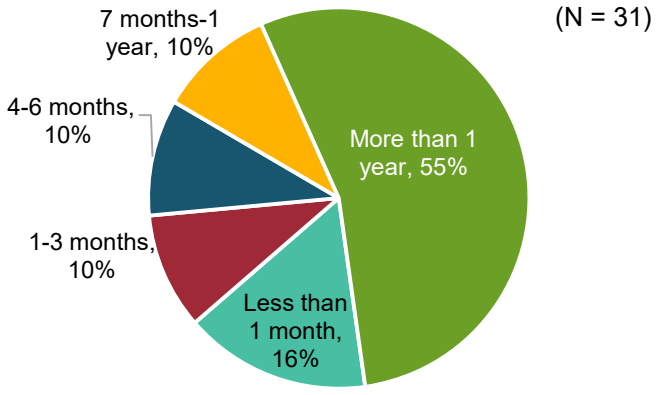
- Friends/peers
- Employment
- Support/advocacy

Suggestions to make this program better: (N=14)

- Already doing well – general
- More time
- More education

How long have you been participating in services?

(N = 31)



Program Outcomes

Growing Works tracks outcomes by surveying participants who receive service and by staff providing services. A survey is completed by participants and staff at three time points (i.e., Intake, Phase 2, and Phase 3) to evaluate initial needs and improved competency as they continue through the program. Results from these surveys are shown in the tables and open-ended program feedback questions that follow.

Participant Self-Assessments	% Agree/Strongly Agree		
	Intake (N=16)	Phase 2 (N=2)	Phase 3 (N=9)
I am comfortable working with people.	94%	100%	88%
I remember and understand instructions.	94%	100%	88%
I am comfortable learning new tasks.	100%	100%	88%
I ask for advice when needed.	81%	100%	75%
I have developed skills that employers want.		50%	63%
I am ready to move into the next phase of employment.		100%	25%

Caution: Total Ns are low and may not be representative of a larger population.

Participant Self-Assessments Program Feedback

What interests you most about Growing Works? (N=15)

Top Responses

- Learning new skills
- Working with plants

What do you hope to learn or achieve at Growing Works? (N=14)

Top Responses

- To get a job at Growing Works
- Learn about plants
- Get to know peers/community

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Growing Works

Program Outcomes

Staff Assessments	% Agree/Strongly Agree		
	Intake (N=11)	Phase 2 (N=8)	Phase 3 (N=0)
Works well with other members and staff.	82%	63%	
Remembers and understands instructions.	72%	63%	
Is comfortable learning new tasks.	64%	63%	
Asks for help when needed.	91%	63%	
Is engaged in their recovery journey and embraces coping skills.	36%	38%	
Has marketable skills.		63%	
Is ready to move on to the next phase of employment.		13%	

Caution: Total Ns are low and may not be representative of a larger population.

Staff Assessments Program Feedback

What are your general observations of this member? (N=12)

Top Responses

- Positive attitude
- Friendly/interacts well
- Seeks attention

What areas of growth or improvement are needed? (N=9)

Top Responses

- Coping skills
- Social interactions
- Seeks attention

Are there any areas of concern (mental health, home life, safety, recovery, etc.)? (N=8)

- No answer given more than once.

General Comments (N=8)

Top Responses

- Positive comments – general
- Poor attendance/tardiness
- Struggles with medication

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Mobile Crisis Outreach for Transitional Age Youth (MCOT)

Program Demographics

FY 23-24 Total Program Cost		$ 342,414
Total Individuals Served		123
Cost Per Individual:		$ 2,783
Served during FY22-23		New Program
Age Group	**N = 123**	
0 - 15 yrs.	1	0.81%
16 - 25 yrs.	99	80.49%
26 - 59 yrs.	22	17.89%
60 & Older	1	0.81%
Gender Identity	**N = 85**	
Female	43	50.59%
Male	40	47.06%
Transgender woman	1	1.18%
Transgender man	1	1.18%
Race	**N = 63**	
White/Caucasian	21	33.33%
Black/African American	4	6.35%
Asian	1	1.59%
Native Hawaiian or Other Pacific Islander	1	1.59%
Other	36	57.14%
Sexual Orientation	**N = 5**	
Heterosexual / Straight	5	100.00%
Ethnicity	**N = 63**	
Hispanic	44	69.84%
Non-Hispanic	19	30.16%
Language Spoken	**N = 83**	
English	71	85.54%
Spanish	12	14.46%
Veteran	**N = 9**	
No	9	100.00%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable

Progress over fiscal year 2023-24 involved mastering the new SmartCare (the county's new electronic health record, educating and presenting program goals to both VCBH community providers and county law enforcement. We also reduced hospitalizations by providing wrap around support services and connecting them to mental health providers.

The team was able to obtain urgent appointments at VCBH clinics and private providers for both Medi-Cal and Non Medi-Cal beneficiaries. The team's main focus was safety planning, working with collateral support teams, and providing warm hands offs to mental health providers. This method allowed for a smooth transition for billing changes in Medi-Cal Crisis Bundled billing.

By employing bi-cultural members in our team, we are equipped to serve the needs of our Spanish speaking population. Our Peer Support specialist is trained in the specific challenges faced within our Transitional Age Youth (TAY) population. Some challenges that this program has faced include lack of a dedicated vehicle, and an even number of staff members to have two full response teams.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

It is vital that staff are properly trained and attuned to the TAY groups' needs. Success in addressing their requirements, reducing psychiatric hospitalization and providing warm hand offs to the correct treatment programs results in the absence of lapses in care for our clients.

Include examples of notable community impact.

The MCOT team was present at multiple community events, such as the Chicano Moratorium in Santa Paula. They've also connected with community members and advocacy groups to educate them on the services available through the program. There has been lots of feedback received from schools and hospital emergency rooms regarding the team's specialized skills in creating strong connections with transitional aged youth that promote positive outcomes.

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Mobile Crisis Outreach for Transitional Age Youth (MCOT)

Success story.

A client was highly agitated and being aggressive towards family members and law enforcement. With the assistance of the MCOT team and Certified Peer Specialist, the situation was able to be de-escalated. This resulted in the client being able to be safely transported via ambulance instead of my law enforcement vehicle. The Peer Specialist's bi-cultural connection to the family was instrumental to the success of this situation.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Mobile Response Team (MRT) for Youth and Families

Program Demographics

FY 23-24 Total Program Cost		**$ 537,878**
Total Individuals Served		20
Cost Per Individual:		$ 26,894
Individuals Served during FY 22-23		New Program
Age Group	**N = 20**	
0 - 15 yrs.	10	50.00%
16 - 25 yrs.	10	50.00%
Gender Identity	**N = 17**	
Female	10	58.82%
Male	7	41.18%
Race	**N = 15**	
White/Caucasian	6	40.00%
Black/African American	1	6.67%
Other	8	53.33%
Sexual Orientation	**N = 1**	
Heterosexual / Straight	1	100.00%
Ethnicity	**N = 14**	
Hispanic	10	71.43%
Non-Hispanic	4	28.57%
Language Spoken	**N = 18**	
English	15	83.33%
Spanish	3	16.67%
Veteran	**N = 7**	
No	7	100.00%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable

The Mobile Response Team (MRT) provides mobile crisis response services to VCBH Youth and Family enrolled clients. The program launched in September of 2023.The services include immediate phone response, mobile crisis response, follow up support, information and referrals. The team responds in the field anywhere within Ventura County where the youth is located within 60 minutes of the individual determined to need an in-person response. The team will work to assist families in preserving the relationship with the individual needing crisis support, providing developmentally appropriate conflict/crisis management and resolution skills, stabilizing the living situation, mitigating the distress of the youth and or caregivers involved, providing the needed resources identified and ensuring this is being done in a trauma informed manner and taking into consideration the youth and family unit's strengths, including cultural and linguistic needs. The team is composed of bilingual staff who deploy, when possible, staff who speak the preferred language, otherwise a language service is readily available. Due to the high need for crisis response/acuity among youth in the community, an identified challenge is that the team is available only to those who are already enrolled with services within the Youth and Family Division.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

MRT works very closely with the Ventura County Youth and Family Division

Include examples of notable community impact.

Due to the staffing shortages within the Ventura County Behavioral Health Crisis Team, the availability of the Seneca MRT team has been a welcome addition as they have been able to free up teams to respond to other individuals of all ages enrolled and unenrolled in mental health services, thus relieving and reducing the utilization of law enforcement response for self-identified mental health crises.

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Forensic Services/Mental Health Courts

Program Demographics

FY 23-24 Total Program Cost	**$375,973**	
Total Individuals Served	135	
Cost Per Individual:	$ 2,784.98	
Individuals Served during FY 22-23	15	
Age Group	**N = 135**	
0 - 15 yrs.	1	0.74%
16 - 25 yrs.	9	6.67%
26 - 59 yrs.	117	86.67%
60 yrs & Older	8	5.93%
Gender Identity	**N = 119**	
Female	28	23.53%
Male	91	76.47%
Race	**N = 109**	
White/Caucasian	44	40.37%
Black/African American	14	12.84%
Asian	1	0.92%
Other	50	45.87%
Sexual Orientation	**N = 16**	
Heterosexual / Straight	16	100.00%
Ethnicity	**N = 101**	
Hispanic	53	52.48%
Non-Hispanic	48	47.52%
Language Spoken	**N = 116**	
English	106	91.38%
Spanish	10	8.62%
Veteran	**N = 8**	
No	8	100.00%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable

The Forensic Services Program has made progress in expanding access to essential mental health and substance use disorder services for justice-involved individuals while also recognizing the need to raise awareness of unserved and underserved populations. To address these gaps, the program continues to collaborate with community partners and stakeholders while developing specialized programs tailored to meet the unique needs of vulnerable groups. Additionally, it has actively worked to reduce ethnic and cultural disparities by increasing the availability of culturally responsive care, including hiring bilingual and diverse staff to enhance communication, build trust, and improve service accessibility for underrepresented communities. By fostering inclusiveness and ensuring equitable access to care, the program continues to create pathways for long-term recovery and successful reintegration. Efforts to improve equity included expanding diversion and alternative sentencing programs, such as mental health courts and specialized treatment plans, to provide individuals with appropriate care rather than incarceration. Additionally, access to services was continued via telehealth options, streamlined intake processes, and transportation assistance, helping to reduce common barriers faced by marginalized communities. These initiatives have yielded promising results, with a reduction in recidivism rates among participants, highlighting the effectiveness of these interventions in promoting long-term recovery and stability. Current challenges include securing placement due to treatment centers operating at full capacity, leading to long waitlists, while high costs and insurance limitations further restrict access. Strict eligibility criteria create additional delays, especially for vulnerable populations such as individuals with dual diagnoses and those with specific felony charges, who face even fewer treatment options.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The Forensic Services Program utilizes a collaborative approach to assess the mental health needs of individuals involved in the criminal justice system. It involves gathering input from stakeholders (DA, PD, sheriff, probation, jail medical, etc.), service providers, and individuals with lived experience to identify key issues such as incarceration, barriers to mental health services, and homelessness. The collaborative planning and program improvement efforts

have successfully addressed numerous barriers to existing mental health diversion and court programs, subsequently enhancing their effectiveness, accessibility, and impact. These efforts have strengthened program coordination, service delivery, and participant outcomes, ensuring that justice-involved individuals, as well as unserved and underserved populations receive the support needed for successful rehabilitation and community reintegration.

Ultimately, these efforts have improved outcomes for justice-involved individuals by enhancing service effectiveness and expanding access to diversion, rehabilitation, and court programs, ensuring more individuals receive the necessary support for long-term stability. Through its diverse and bilingual staff, the Forensic Services Program has increased awareness and accessibility of mental health and substance use services for justice-involved individuals as well as unserved and underserved populations. By offering culturally and linguistically responsive care, the program helps Spanish-speaking individuals overcome language barriers and cultural stigmas, ensuring better engagement with available resources. This fosters trust, participation, and improved rehabilitation outcomes. The Forensic Services Program ensures coordinated support for justice-involved individuals with mental health and co-occurring disorders through oversight and weekly team meetings. By eliminating service gaps, improving workflows, and enhancing data collection, the program fosters accountability and efficiency. Addressing the root causes of justice involvement, the program promotes safer communities, reduces strain on services, and supports reintegration.

Include examples of notable community impact.

- The program has enhanced community well-being through targeted initiatives that address the needs of justice-involved individuals and underserved populations:

- Reduced Recidivism: By diverting individuals with mental illness and substance use disorders into treatment programs instead of incarceration, the county has experienced notable progress through its mental health diversion and court programs. As a result, program participants have successfully lowered recidivism rates and achieved sustained reintegration into the community.

- Improved Housing Stability: Through partnerships with transitional housing and contracted supportive housing programs, the Forensic Services Program has helped individuals secure stable housing, reducing homelessness among justice-involved individuals and increasing long-term housing stability.

- Successful Diversion through Mental Health Court Programs: Specialized mental health court programs have led to lower recidivism rates in specific cases by offering mental health treatment, case management, and life skills training in place of incarceration. Many individuals who complete these programs achieve long-term recovery and reintegration into society, breaking the cycle of repeated criminal justice involvement.

- Crisis Response and De-Escalation: Through law enforcement partnerships and appropriate crisis intervention training, the Forensic Services Program has strengthened its ability to respond to mental health crises among incarcerated individuals, ensuring they receive appropriate care and services during mental health emergencies.

- Improved Treatment Engagement: Tailored interventions and culturally responsive services have led to an increase of treatment adherence, particularly among individuals with mental illness who are disproportionately affected by the criminal justice system.

- Enhanced Community Safety: By diverting individuals with mental health conditions from jail to appropriate treatment, the program has implemented validated risk and violence assessments to ensure appropriate care and support.

- Strengthened Collaboration: The program has fostered strong partnerships between mental health providers, law enforcement, public defenders, district attorneys, community organizations and the Court, creating a more coordinated and effective response to mental health crises.

Success story.

This success story begins with an individual who has an extensive arrest history throughout their lifetime and was once again in custody on felony charges. With limited support and years of homelessness, the client has a history of multiple suicide attempts, including attempts at “suicide by cop,” highlighting their challenges with mental health and crisis management. Recognizing the severity of the situation, the clients’ representative filed a motion for mental health diversion, bringing the matter to the attention of the Forensic Services Program due to the individuals' incarceration. However, there was strong opposition from both the prosecution and the arresting police department, who viewed incarceration as the only viable option.

Facing what seemed like insurmountable odds, the individual had little hope of accessing rehabilitative programming, as a five- to eight-year prison sentence was strongly pursued. Despite this, the Forensics Team remained steadfast in their advocacy, conducting a formal risk assessment and presenting their findings to the court. The presiding judge took note of the client’s tumultuous past and the lack of opportunities they had been given to truly succeed. After careful consideration, the court granted mental health diversion, setting the individual on a new path.

Following the ruling, the client was placed in a secure facility after spending a year in county jail. As the client began to show signs of progress, the Forensic Services Program meticulously evaluated potential long-term placements to ensure the best chance for success. Eventually, the client was transferred to a residential board and care facility, where they continued to receive rehabilitative services through individual and group counseling, substance use treatment, medication management, ongoing stabilization and support.

Over the course of two years in mental health diversion, the individual engaged in intensive therapy, group therapy, and substance use education while simultaneously receiving appropriate mental health services. With the support and structure provided by the Mental Health Diversion Program, the client successfully completed treatment and recently graduated from the program. The Forensics Team was notified of this milestone and, in collaboration with community partners, secured the client a placement at a more substance-use-focused board and care facility. This next step will allow the client to continue developing essential life skills and social rehabilitation strategies, further solidifying their path toward a stable and fulfilling life.

This story serves as a testament to the dedication of the Forensic Services Program in advocating for individuals who require intensive case management and substance use services, psychiatric care coordination, housing assistance, and social rehabilitation training needed to succeed. Through comprehensive wraparound services, strategic placement, and a commitment to rehabilitation, the program continues to provide individuals with the support they need to break cycles of incarceration and build a future filled with hope and opportunity.

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Mental Health Diversion Grant Program

Program Demographics

FY 23-24 Total Program Cost		$259,003
Total Individuals Served		93
Cost Per Individual:		$2,785
Age Group	**N = 93**	
16 - 25 yrs.	7	7.53%
26 - 59 yrs.	79	84.95%
60 yrs & Older	7	7.53%
Gender Identity	**N = 89**	
Female	25	28.09%
Male	64	71.91%
Race	**N = 84**	
White/Caucasian	37	44.05%
Black/African American	1	1.19%
Asian	2	2.38%
Other	43	51.19%
More Than One Race	1	1.19%
Sexual Orientation	**N = 20**	
Heterosexual / Straight	20	100.00%
Ethnicity	**N = 83**	
Hispanic	39	46.99%
Non-Hispanic	44	53.01%
Language Spoken	**N = 91**	
English	88	96.70%
Spanish	2	2.20%
Vietnamese	1	1.10%
Veteran	**N = 19**	
No	19	100.00%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable

The Mental Health Diversion Program recognizes the growing need to ensure timely access to mental health assessments, diversion screenings, and treatment referrals, providing eligible individuals with appropriate care. Through collaboration with our community-based mental health providers and justice involved partners, the program continues to expand access to culturally competent services, which ultimately enhances the effectiveness of interventions for diverse populations. Furthermore, case management services were systematically enhanced through interagency collaboration to ensure comprehensive support for Mental Health Diversion participants. These efforts aim to facilitate adherence to treatment plans, mitigate the risk of recidivism, and promote long-term stability. Moreover, staff awareness of cultural competency, implicit bias, and trauma-informed care continues to be emphasized to enhance service delivery, ensuring a more inclusive, responsive, and effective approach to meeting the unique needs of program participants.

Participation in the Mental Health Diversion Program has increased among communities disproportionately affected by the criminal justice system, particularly minority groups. Tailored interventions and culturally responsive support (e.g., bilingual staff) have improved engagement and treatment adherence. Efforts to reduce barriers such as language access, transportation, and mental health stigma have further enhanced accessibility. The program remains committed to expanding these initiatives to improve outcomes and promote long-term stability. Several key factors have contributed to the success of the program, most notably the establishment of a dedicated forensics team and the implementation of a multidisciplinary, collaborative approach. This approach has been instrumental in enhancing awareness among clinical providers regarding the unique needs of individuals involved in the criminal justice system. By fostering stronger coordination between mental health services and legal entities, the program has improved service accessibility, facilitated more effective treatment interventions, and ensured that clients receive the necessary support to navigate both their mental health needs and legal circumstances. Collaborative planning and ongoing program improvements have strengthened the diversion program, helping it overcome key barriers and achieve greater success. However, the program continues to face challenges due to the limited availability of residential treatment and supportive housing options. Currently, there is a shortage of licensed residential treatment beds, mental health Board and Care facilities with 24/7 staffing, and well-managed sober living homes. This shortage makes it difficult to find stable placements, particularly for high-acuity individuals requiring intensive care. Limited housing options have created significant obstacles to providing consistent support for mental health clients. Because of this, the Mental Health Diversion Program has prioritized housing assistance for high-risk individuals, ensuring they have access to stable and supportive living environments.

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Mental Health Diversion Gant Program

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The Mental Health Diversion Program directly addresses key community issues identified in the County's Community Program Planning Process, including homelessness, incarceration, and the lack of services for unserved and underserved populations. By providing early intervention, comprehensive mental health assessments, and diversion screenings, the program reduces the likelihood of incarceration for individuals with mental health conditions. Tailored case management services connect participants to essential resources such as housing, employment, education, and healthcare, addressing social determinants of health that contribute to instability. Additionally, the program prioritizes culturally responsive care to ensure equitable access for historically marginalized communities, thereby expanding services to those who have been unserved or underserved. Through these efforts, the program enhances public safety, promotes long-term recovery, and fosters community reintegration. By providing timely mental health assessments, diversion screenings, and treatment referrals, the program offers an alternative to incarceration for individuals whose offenses are linked to untreated mental health conditions. This approach not only reduces the jail population but also ensures that participants receive the care they need to stabilize and reintegrate into the community.

In addressing homelessness, the program collaborates with housing providers and supportive service organizations to connect participants with stable housing options. Many individuals involved in the criminal justice system face significant housing insecurity, which can be a barrier to successful treatment and rehabilitation. By integrating mental health services with housing support, the program helps participants establish a foundation for long-term recovery and reduces the likelihood of recidivism. Furthermore, the program actively works to expand access to care for unserved and underserved populations, including individuals from historically marginalized communities. Through culturally responsive treatment approaches and partnerships with community-based providers, the program ensures that services are inclusive and accessible. Outreach efforts focus on reducing stigma and increasing awareness of available mental health resources, particularly among populations that have historically faced barriers to care. By addressing these critical community concerns, the Mental Health Diversion Program plays a vital role in promoting public safety, reducing recidivism, and improving the overall well-being of individuals with mental health needs in the justice system. The program remains committed to enhancing service accessibility, strengthening community partnerships, and implementing data-driven strategies to ensure continued positive outcomes.

Include examples of notable community impact.

The Mental Health Diversion Program has made a significant impact on the community by reducing incarceration rates, improving mental health outcomes, and enhancing access to essential services. Notable examples of its success include:

- Reduced Recidivism: Participants who received mental health support and case management showed a marked decrease in repeat offenses, demonstrating the program's effectiveness in breaking the cycle of incarceration.
- Improved Treatment Engagement: Tailored interventions and culturally responsive services have led to higher rates of treatment adherence, particularly among minority groups disproportionately affected by the criminal justice system.
- Enhanced Community Safety: By diverting individuals with mental health conditions from jail to appropriate treatment, the program has contributed to a safer community environment while aiming to reduce the burden on the criminal justice system.
- Strengthened Collaboration: The program has fostered strong partnerships between mental health providers, law enforcement, public defenders, district attorneys, community organizations and the Court, creating a more coordinated and effective response to mental health crises. Through these initiatives, the Mental Health Diversion Program continues to drive meaningful changes, improving lives while promoting public health and safety.

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Adult Wellness Center and Mobile Wellness

Program Demographics

FY 23-24 Total Program Cost		**$1,116,360**
Total Individuals Served		865
Cost Per Individual:		$ 1,290
Individuals Served during FY 22-23		864
Age Group	**N = 877**	
16 - 25 yrs.	56	6.39%
26 - 59 yrs.	637	72.63%
60 & Older	172	19.61%
Declined to Answer	12	1.37%
Gender Identity	**N = 879**	
Female	301	34.24%
Male	534	60.75%
Other	5	0.57%
Unsure / Questioning	2	0.23%
Transgender	2	0.23%
Declined to Answer	35	3.98%
Race	**N = 629**	
White/Caucasian	309	38.29%
Black/African American	41	5.08%
Asian	13	1.61%
Native Hawaiian or Other Pacific Islander	8	0.99%
Alaska Native or Native American	18	2.23%
Other	22	2.73%
More Than One Race	218	27.01%
Latino/Hispanic	113	14.00%
Declined to Answer	65	8.05%
Sexual Orientation	**N = 877**	
Bisexual	25	2.85%
Other	10	1.14%
Heterosexual / Straight	701	79.93%
Queer	4	0.46%
Unsure / Questioning	5	0.57%
Gay or Lesbian	23	2.62%
Declined to Answer	109	12.43%
Ethnicity	**N = 702**	
Hispanic	427	37.82%
Non-Hispanic	126	11.16%
Declined to Answer	78	6.91%
More Than One Ethnicity	71	6.29%
Hispanic	427	37.82%

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable

- Administrative staff are continuing to work on developing a fully formed career ladder for Peer Staff within the Wellness Center which would highlight different levels of certification, including being certified as a Medi-Cal Peer Support Specialist, being certified as a WRAP group facilitator, and being certified as an Advanced Level WRAP group facilitator. This would be in addition to potential promotions to Leadership positions within the agency

- The Program Manager continues to build connections with outside agencies in order to increase the Mobile Wellness Service sites provided to the community. At the present moment, Mobile Wellness provides services to a total of 9 different residential programs.

- After receiving Advanced Level Facilitator Certification, TWC staff have begun providing WRAP Group Facilitation Trainings to outside agencies as a means of increasing collaboration with outside Peer Support Services.

- Overall member enrollment increased by over 300 participants from the beginning of the 23-24 fiscal year to the end.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues.

- TWC have developed a partnership with United Parents group and provide a bi-weekly parent support group in the evenings for Spanish speaking members within the community

- TWC continues to always establish a consistent ratio of 50% bilingual staff

- CALMHSA funding has enabled TWC to remain open to the public without requiring any form of insurance, payment or referral. The program increases access to recovery services by offering support without the pressure of enrolling in traditional mental health services. As a result, staff are able to provide services for individuals regardless of insurance, income, or any other barrier that would prevent an individual from being able to receive services.

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Adult Wellness Center and Mobile Wellness

Program Demographics, Con't.

Language Spoken	N = 876	
English	639	72.95%
Mixteco	2	0.23%
Spanish	115	13.13%
Multiple Languages	110	12.56%
Declined to Answer	10	1.14%
Veteran	**N = 399**	
Yes	168	42.11%
Declined to Answer	53	13.28%
No	178	44.61%
Disability		
Communication		
Seeing		229
Hearing or Having Speech Understood		103
Other		3
Mental (Not SMI)		
Learning Disability		125
Developmental Disability		41
Dementia		7
Other		3
Physical/Mibility Disability		104
Chronic Health Conditions/Chronic Pain		220
Other Disability		18

Include examples of notable community impact.

The Wellness Center continues to offer free services throughout the community to vulnerable populations through a combination of the in-person center in South Oxnard and the off-site services provided to nine separate programs through the usage of Mobile Wellness services. The program increases access to recovery services by offering support without the pressure of enrolling in traditional mental health services. The Adult Wellness Center reaches out to underserved individuals, low-income populations, monolingual Spanish-speaking populations, and homeless populations throughout the county, offering an array of on-site and off-site supports and referrals to those who historically have not accessed services through the traditional behavioral health clinic system. CALMHSA funding has enabled TWC to remain open to the public without requiring any form of insurance, payment or referral. The program also provides support for individuals as they transition out of other mental health programs. The program was designed and is run by peers who support members in designing their own unique recovery plans and creating meaningful goals utilizing the Wellness Recovery Action Plan (WRAP) in English and Spanish. Mobile Wellness Services provides support and facilitates four WRAP groups per week at the Wellness Center, plus six WRAP groups per week off-site in the community for underserved populations including Board and Care, transitional and homeless services, and Veteran Services.

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

TAY Wellness Center

Program Demographics

FY 23-24 Total Program Cost		**$ 560,609**
Total Individuals Served		162
Cost Per Individual:		$ 3,460
Individuals Served during FY 22-23		111
Age Group	**N = 162**	
16 - 25 yrs.	159	98.15%
26 - 59 yrs.	3	1.85%
Gender Identity	**N = 119**	
Female	56	47.06%
Male	60	50.42%
Genderqueer	2	1.68%
Other	1	0.84%
Race	**N = 138**	
White/Caucasian	23	16.67%
Black/African American	13	9.42%
Asian	5	3.62%
Alaska Native or Native American	2	1.45%
Other	83	60.14%
More Than One Race	12	8.70%
Sexual Orientation	**N = 137**	
Lesbian or Gay	5	3.65%
Heterosexual / Straight	76	55.47%
Bisexual	23	16.79%
Queer, pansexual, and/or questioning	11	8.03%
Other	5	3.65%
Declined to Answer	17	12.41%
Ethnicity	**N = 25**	
Non-Hispanic	17	68.00%
More Than One Ethnicity	8	32.00%
Language Spoken	**N = 132**	
English	97	73.48%
Spanish	35	26.52%
Veteran	**N = 123**	
No	123	100.00%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The TAY Tunnel serves all transitional aged youth (TAY) ages 18–25 dealing and recovering from mental illness and/or substance use at Ventura County. The center empowers individuals to take an active role in creating positive lifestyle changes within a supportive, safe, and welcoming environment. 4 full time and 3 part time staff, 3 of the 7 staff are bilingual, all staff with lived experience provide peer driven activities such as the development of achievement plans, Wellness and Recovery Action Plans (WRAP), employment services, creative expression, advocacy, housing linkage, health navigation, SMART recovery, linkage to mental health and other community activities critical to their recovery & independence. Through the Homeless Management Informational System (HMIS) the TAY Tunnel has been able to have individuals complete a Vulnerability Index and the Service Prioritization Decision Assistance Tool. The assessment will improve the chances for the youth to access permanent supportive housing while receiving services at the center.
To address the growing need to provide substance abuse services at Ventura County, the center uses the harm reduction approach and participates in the Naloxone Distribution Project and distribution of Fentanyl strips. The center provides free Narcan training to providers and transitional age youth as well as their support network while providing linkage to other substance abuse services in the community to maintain sobriety.

Self-Management and Recovery Training (SMART Recovery) are also offered twice a week by a certified staff. SMART Recovery is a four-point program which are:

1) Building and maintaining motivation,
2) Coping with urges,
3) Managing thoughts, feelings and behavior,
4) Living a balanced life. Trained staff can assist TAY with self-reliance

As SMART membership continues to grow, the TAY Tunnel is looking to add one certified facilitator so the service could be offered 4 times per week for clients to access either in-person or virtually.

The TAY Tunnel also provides an array of opportunities to find meaningful role in life in their community such employment services and Medical Peer Training Certification. In the new fiscal year, the Center will continue to create partnerships to increase its education workshops for youth to access. A good example of this is our continued relationship with Planned Parenthood Partnership, which offers a variety of health workshops. As part of our continuous quality improvement (CQI), the center is proud to identify that most of our peer services providers are Medical Peer Certified. We would also like to seek to have our peer providers pursue certification in other evidence-based practices such as IPS Employment and Education if there is available funding to be accessed.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues.

To ensure that we meet the needs of the participants there is a weekly TAY Council. The TAY Council is facilitated by staff who are peers and is open to all members and visitors. During TAY Council participants are encouraged to bring forth questions and concerns. To capture the voices of those unable to attend TAY Council we implemented a comment, suggestions, and a concern box that individuals can use to communicate with the center and fellow participants. Classes, activities, and outings offered, supplies purchased and even décor suggestions are some of the things discussed at TAY Council. Through TAY Council we have been able to collaborate with members to facilitate the following Activities:

• Pens and pastries in the month of February focused on personal growth, self-love and building connections and support.

• The Getty Museum- focused on providing cultural and arts experience.

• Self-Identity Workshop presented by Planned Parenthood- LGBTQ focused workshop.

• Summer BBQ – is our annual celebration where we highlight individuals' achievements and successes. It is also a way we show appreciation to our participants.

• Art at the Park – individuals went to the Oxnard beach park and created art pieces. It was a way of promoting positive coping skills.

• On Wednesday we wear pink. Shinning a light on bullying and discussing the importance of self-love, compassion, empathy, and building positive self-regard for ourselves and others.

• Ice Cream Social/ Video game tournament – Fun social event to help build community.

• Movie Spooktacular- watched a Halloween themed movie and enjoyed refreshments.

• Fall Feast- Provides a safe place for the holidays for individuals how may not have supports or families to meet with. Also, it provides a chance for those who do have them to support their fellow participants.

• Winter wonderland- Also, provides a safe place for the holidays for individuals how may not have support or families to meet with. Also, it provides a chance for those who do have them to support their fellow participants.

Classes that facilitated this past fiscal year are:

• Youth Wellness Recovery Action Plan (WRAP)- During this class members develop their own Wellness Recovery Action Plan.

• Creative Expression- Members are encouraged to use various artistic mediums to express themselves.

• Holistic-U- Focuses on the complete well-being of an individual by considering various dimensions, including physical, mental, emotional, social, nutritional, and occupational aspects of their lives.

• Creative Writing- Members are encouraged to present their creativity in written form to develop healthy emotional expression.

• Job Preparation- Employment techniques and tools such as resume writing and interviewing are explored.

• Self-Management and Recovery Training (SMART) - SMART aids individuals seeking abstinence from addiction. Two staff are certified in SMART recovery which is a science-based program.

• TAY Council**- Members and staff discuss concerns, events, and make suggestions to improve TAY services.

• Expresión creativa- Creative Expression in Spanish

• Positive Interaction- Series of activities that promote positive social interactions.

• Wellness Wheel- Our Wellness Wheel Activity will be focusing on the 8 dimensions of wellness; members will create their own wheel that is unique to them.

• WRAP in Color- WRAP in color is a way of coloring your wellness by learning the 5 key concepts of WRAP.

• Wellness Toolbox- Members will understand their own Wellness Toolbox by creating activities or utilizing items that help guide and lift their spirits, emotions, and physical wellbeing.

• Movie Flicks- Kick back and unwind with a flick on a Friday

Additional services offered are assistance with education, employment, and career exploration and development.

The TAY tunnel also utilizes Ventura County Homeless Management Informational System to provide housing linkage to participants. As well as working with local housing and homeless resource providers. The program also has assisted individuals establish healthier preventative care habits. Qualifying youths are able to access Health Navigation services as part of our integrated care to support the individual in managing medical issues that could limit their independence.

The TAY Tunnel staff also participates in our agencies LGBTQ+ Education Advancement and Development of Services (LEADS) Network. It is an employee-led resource group with a vision to inform and build inclusive, sensitive and affirming LGBTQ+ services and culture. LEADs Committee. Through their participation in LEADS they have been able to bring new initiatives to the center. Historically, TAY Tunnel has attended local Pride events and Models of Pride. TAY Spectrum is a group geared to our LGBTQ+ participants. Staff bring awareness to LGBTQ+ issues and work with the local LGBTQ+ Center to refer youth. There is also a LGBTQ resource section in our resource area and within the restrooms.

COMMUNITY SERVICES AND SUPPORTS (CSS)
General System Development (GSD)
TAY Wellness Center

Include examples of notable community impact.

Pacific Clinics TAY Tunnel serves the unserved and underserved Transitional Aged Youth (TAY) throughout all of Ventura County. Primarily focusing on those individuals with mental health and substance use issues. Along with mental health and substance abuse issues Pacific Clinics also assist individuals who are facing challenges with housing insecurity and homelessness, criminal justice involvement, current and former foster youth, LGBTQ+, and individuals living below the poverty line to name a few.

Pacific Clinics TAY Tunnel is a drop-in center that is peer run and peer driven. Accessible at no direct cost to participants. Staff assist TAY to identify areas of their lives that need support and assist them in obtaining links to the appropriate agency to address their needs. For example, there are staff who are Individual Placement and Support (IPS) certified that assist participants find and retain employment and explore careers. Staff are available to help individuals facing housing insecurities or homelessness through access to the Homeless Management Informational System (HMIS). HMIS is Ventura Counties data collection and housing linkage system. Pacific Clinics TAY Tunnel facilitates Self-Management and Recovery Training (SMART) is an evidenced-informed recovery method grounded in Rational Emotive Behavioral Therapy (REBT) and Cognitive Behavioral Therapy (CBT), that supports people with substance dependencies or problem behaviors to: Build and maintain motivation, cope with urges and cravings, manage thoughts, feelings and behaviors, and live a balanced life.

Pacific Clinics TAY Tunnel additionally provides daily wellness-based classes like the Wellness Recovery Action Plan (WRAP). WRAP is a framework with which an individual can develop an effective approach to overcoming distressing symptoms, and unhelpful behavior patterns. This plan is developed with the guidance from our Peer Support staff most of who are certified threw the state of California as Medi-Cal Peer Support Specialist. Peer Support staff walk alongside our participants on their self-driven journey to wellness and recovery. Pacific Clinics TAY Tunnel strives to meet our participants where they are at and to assist them in eliminating barriers to accessing services and obtaining basic needs. Within the center we provide access to shower, laundry, kitchen, phone, and computers to name a few. Participants can access personal and wellness products like hygiene supplies, clothing, menstrual products, sexual health products, NARCAN and Fentanyl Test Strips.

Pacific Clinics TAY Tunnel staff provide step by step support utilizing a “for them, with them, by them” model when linking individual to our fellow community partners. We work with other community organizations to ensure a warm hand off when linking individuals to attempt to avoid barriers and delays in accessing services.

COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

TAY Wellness Center

This program distributes satisfaction surveys twice yearly for a duration of one month each time. These Client Perception and Satisfaction Survey results are shown below.

Please indicate how much you disagree or agree with the following statements:	% Agree/Strongly Agree
	(N = 22-24)
Staff were sensitive to my cultural background (e.g., ethnic/religious beliefs).	82%
Services were available in my preferred language.	88%
I was able to get connected to the services I thought I needed.	92%
Overall, I am satisfied with the services I received.	100%
I would recommend these services to a friend or family member.	100%
As a result of participating in this program:	**% Agree/Strongly Agree**
	(N = 23-24)
I am happier with the friendships I have.	71%
I have people with whom I can do enjoyable things.	67%
I do better in social situations.	75%
My housing situation has improved.	78%
I feel like I belong in my community.	75%
I feel better about myself.	91%
I am better able to handle things when they go wrong.	92%

Most useful or helpful about this program: (N = 24)

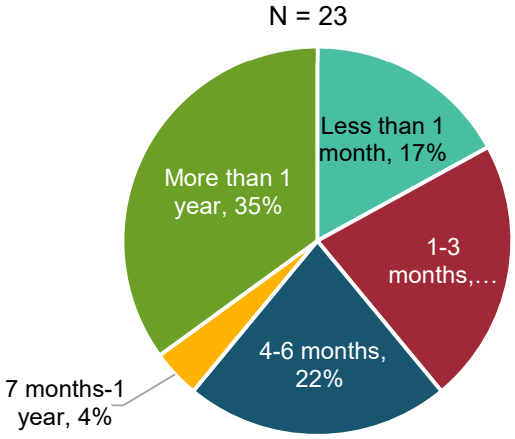
- The staff
- Space to hang out/decompress
- The services

Suggestions to make this program better: (N = 17)

- Already doing well (general)
- Help with housing
- More transportation/trips

How long have you been participating in services?

N = 23



COMMUNITY SERVICES AND SUPPORTS (CSS)

General System Development (GSD)

Language Services

Population Served	
Total Served	1,594
Cost per client	$ 295.85
Total to be served next year:	1,650

Languages Spoken	
English	-
Spanish	1,444
Vietnamese	12
Cantonese	1
Mandarin	5
Tagalog	2
Cambodian	-
Hmong	-
Russian	3
Farsi	6
Arabic	2
*Other	60

*Encompasses clients who speak languages such as: American Sign Language (16), Armenian (1), Khmer (1), Korean (2), Lao (1), Mixteco (32), Portuguese (1), Thai (3), Triqui (1), Turkish (1), Urdu (1)

Over the past year, VCBH Language Services transitioned from Avatar to SmartCare within operations. The data may not encompass all of the individuals served and their linguistic service needs as VCBH is working with CalMHSA and Streamline to refine tracking and data management capabilities to enhance service delivery. VCBH is continually assessing tracking systems to ensure they align with our operational needs and goals

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

While the Office of Health Equity has navigated challenging staffing transitions, these experiences have highlighted opportunities to strengthen program structure and enhance communication pathways. By encouraging open dialogue, the staff aim to address staff concerns more effectively and create a strong communication pathway. This commitment to transparency and collaboration is essential to continually improve language accessibility, interpretation, and translation services. Addressing these areas will allow clients whose primary language is not English, including those who speak Spanish as the County's threshold language, to connect more effectively to VCBH services.

From July to January of FY23-24, the Division Chief of Access and Outreach led the Office of Health Equity, ensuring program performance during the vacancy of the CC/ESM position. During this time, the Division Chief supported staff in coordinating linguistically appropriate interpretation and translation services to meet clients' needs. VCBH partners with multiple providers guarantee access to services in clients required or preferred languages, ensuring that language or cultural differences never hinder individuals or families from receiving care. Under the Division Chief's leadership, the team also successfully established a new contract with a language service provider, expanding interpretation services to include indigenous languages such as K'iche', Poqomchi', Q'eqchi', Nahuatl, and more

Following the onboarding of a new Program Administrator for the Office of Health Equity, oversight of the program was transitioned to the Strategy, Planning, and Administrative Services unit in February 2024. The Strategic Initiatives Behavioral Health Manager currently serves as a CC/ESM role. Throughout the fiscal year, the Office of Health Equity has maintained programming performance by assisting staff in connecting clients with appropriate interpretation and translation services. In response to staff feedback on the complexities of navigating language assistance services, the office began developing operational guidelines to clarify access and use of VCBH's contracted language providers. Additionally, the Office of Health Equity team have collaborated with clinical teams, attending staff meetings to address any concerns regarding language support access. The team also completed and submitted VCBH's required FY23-24 Cultural Competency Plan Annual Update to DHCS, with the final document now available on the VCBH website.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Language Services

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

While a staffing vacancy limited the Office of Health Equity's participation in the County's Community Program Planning Process during the first half of the fiscal year, the program is committed to actively engaging in the upcoming year. This involvement will enhance our support in addressing community-identified needs and contribute meaningfully to department initiatives.

Include examples of notable community impact.

VCBH was connected to a family, whose preferred language of communication was Nahuatl, to provide services. However, none of VCBH's contracted providers were able to support the interpretation need for the family. The Office of Health Equity began searching for language providers who offer interpretation services for the preferred language of the family. The program successfully found a provider who offered Nahuatl interpretation services and initiated an emergency purchase order. The family was able to be successfully connected to VCBH services following the completion of the purchase order. While the emergency purchase order was being completed, the team was simultaneously working on establishing a contract with the provider for the remaining months of the fiscal year. This was successfully completed, and the provider became a contracted provider for VCBH. This allowed the family to schedule a follow-up appointment with VCBH and continue to receive services in their preferred language. The establishment of a contract with this service provider also had notable community impact as VCBH now had a provider who offered interpretation and translation services for harder to find indigenous languages not previously covered by existing VCBH contracted language service providers.

Success story.

In another instance, VCBH staff was experiencing issues in scheduling interpreters for Cantonese, Farsi, and Turkish for clients. The Office of Health Equity connected with both VCBH contracted providers and staff to clearly identify the conflicts preventing scheduling interpretation services for the clients. This outreach allowed the Office of Health Equity to find that the department's policy was worded in a manner that made it seem that clinics not within the East County were not allowed to utilize another one of VCBH's contracted language providers. After confirming with upper management and the contracted provider, the Office of Health Equity attended staff meetings to inform staff that they could utilize any of VCBH's contracted providers needed to meet a client's language needs. In addition to this, the Office of Health Equity submitted a request to revise the policy and remove the wording causing the misunderstanding. This request was approved, and the policy was updated. This resolution allowed staff to more effectively schedule interpreters for the three languages needed for VCBH clients. The result of the policy revision also contributed to notable community impact by enabling VCBH staff to more efficiently and effectively connect with our various contracted language service providers to schedule interpretation services for clients across the entire county.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Housing (HOU)

The Housing category under CSS embodies both the individual and system transformational goals of MHSA by facilitating collaboration among County organizations and resources to ensure that consumers have access to an appropriate array of services and support. VCBH oversees a variety of housing resources for vulnerable clients, people living with homelessness as well as clients who may be provisionally housed and/or underserved.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Housing

FY23-24 Total Program Cost	$1,072,746.47
Total Individuals Served	168
Cost Per Individual	$ N/A*
Target for Fiscal Year 2024-2025	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

VCBH received Community Care Expansion Grant funding allowing the department to provide capital improvements and operating funds for Board and Care Providers in addition to MHSA supplemental funding for licensed Board and Care residents. Client residents of licensed Board and Care facilities are extremely vulnerable and underserved due to both their mental health diagnosis and the fact that they are extremely low income. At the time of implementation of the CCE program demographics of beneficiaries were as follows: Universe = 168 beneficiaries. 55% Caucasian, 11% African American, 29% LatinX, 3% Asian, 1% Pacific Islander and 1% Other Race. 2) VCBH continued to support extremely low income clients with a Capitalized Operating Subsidy Reserve (COSR) account for Paseo Santa Clara, an affordable community owned and operated by Cabrillo Economic Development Corp. 3) Additionally, VCBH continues to support low-income clients with MHSA funding at four affordable housing developments, managed by Many Mansions - Peppertree Apartments, D Street Apartments, Hillcrest Villas and La Rahada. Lastly, VCBH continues to serve 6 families with rental assistance at E Street Apartments in Oxnard.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues.

The licensed care facilities, FSP clients and extremely low income clients living in subsidized apartments continue to benefit from the MHSA Housing programs.

Include examples of notable community impact.

The expansion of family housing at E Street Apartments is notable. VCBH was able to increase this housing type from 4 apartments to 6.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Housing

MHSA Housing Type	Facility Name	Potential Units
ARF - Board and Care (B & C) Ages 18-59	Brown's Board and Care	10
	Cottonwood	20
	Thompson Place	27
	Saundra's Jarmon's Board & Care	3
	Sunrise Manor	46
ARF - Residential Care for the Elderly (RCFE) Age 59+	Oak Place	36
	The Elms	45
	Total Potential Beds	187

MHSA Housing Type	Facility Name	Potential Units
Permanent Supportive Housing	Hillcrest Villa Apartments	15
	Paseo De Luz	23
	Paseo Del Rio/Santa Clara	15
	MC3	6
	La Rahada – Simi Valley	8
	Peppertree – Simi Valley	11
	D Street Apartments – Oxnard	7
	Total Potential Permanent Supported Housing Units	85

COMMUNITY SERVICES AND SUPPORTS (CSS)

Prevention and Early Intervention (PEI)

Programs under the PEI component, in collaboration with consumers and family members, serve to promote wellness, foster health, and prevent the suffering that can result from untreated mental illness. Target populations include all ages with a requirement of serving children and TAY (0-25 years) utilizing 51% of PEI funds.

Ventura County categorized all PEI-funded programs to align with regulations' requirements and definitions. The required program types are prevention, early intervention, outreach for increasing recognition of early signs of mental illness, access and linkage to treatment and stigma and discrimination reduction. Suicide prevention and improving timely access to services for underserved populations are optional categories. Additionally, all PEI-funded programs are designed and implemented in accordance with strategies that help access and services for people with severe mental illness, the reduction of stigma and discrimination with respect to mental illness and improving timely access to mental health services for individuals and/or families from underserved populations in ways that are non-stigmatizing, non-discriminatory and culturally appropriate.

Data Collection Instruments

In the context of ensuring the efficacy of PEI programs, this section articulates the systematic approach towards assessing the impact of these initiatives. Grounded in the guidelines set forth by the California Code of Regulations for the Mental Health Services Act (MHSA), the framework endeavors to understand the pathways through which PEI programs achieve their objectives.

PEI programs employ a variety of data collection instruments, based on the program category to measure the impact each program is having on clients. Instruments have been carefully selected and constructed to ensure alignment with the MHSA regulations and appropriateness for program operations. Methods employed include direct, indirect, and quasi-indirect measures of change, adapted to what is best suited for each individual PEI program.

For all Stigma and Discrimination Reduction programs, the California Code of Regulations calls for validated methods to measure changes in attitudes, knowledge, and/or behaviors related to mental illness or seeking mental health services for Stigma and Discrimination Reduction Programs. The Mental Help Seeking Attitudes Scale (MHSAS) is used to measure respondents' overall evaluation of their seeking help from a mental health professional if they find themselves dealing with any type of mental health concern (Hammer, Parent, & Spiker, 2018). Other Prevention or Early Intervention programs utilize the Schwartz Outcome Scale-10 (Schwartz & Michael, 2000) as an indirect measure of a broad domain of psychological health. These tools, among other constructed tools that meet the highest standards of survey item construction, provide insight into the impacts that PEI programs are having within the community.

The full evaluation report can be found in the Appendix section of this report.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Prevention and Early Intervention (PEI)

Program	PEI Program Categories						
	Prevention	Early Intervention	Outreach for Increasing Recognition of Early Signs of Mental Illness	Stigma & Discrimination Reduction	Access and Linkage to Treatment	Suicide Prevention*	Improving Timely Access to Services for Underserved Populations*
Multi-Tiered System of Support Ventura County Office of Education							
Wellness Centers Expansion K-12 Ventura County Office of Education							
One Step a La Vez							
Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) County of Ventura Human Service Agency Area on Aging (HSA)							
Project Esperanza Our Lady of Guadalupe Parish							
Promoviendo Program Promotoras y Promotores Foundation (PYPF)							
Healing the Community Mixteco Indigena Community Organization Project (MICOP)							
Tri-County GLAD							
Wellness Everyday and STAY Media Campaign Idea Engineering, Inc							
STAY Media Campaign Idea Engineering							
Ignite Catalyst Church							
Network Expansion Grants Program Prevention							

COMMUNITY SERVICES AND SUPPORTS (CSS)
Prevention and Early Intervention (PEI)

Program	PEI Program Categories						
	Prevention	Early Intervention	Outreach for Increasing Recognition of Early Signs of Mental Illness	Stigma & Discrimination Reduction	Access and Linkage to Treatment	Suicide Prevention*	Improving Timely Access to Services for Underserved Populations*
COMPASS							
Seneca Family of Agencies							
Primary Care Program Clinicas del Camino Real, Inc.							
Ventura County Power Over Prodromal Psychosis (VCPOP) Ventura County Behavioral Health							
Network Expansion Grants Program Early Intervention							
Crisis Intervention Team (CIT) Ventura County Law Enforcement							
Diversity Collective							
Network Extension Grants Program Other PEI: : OPAC							
Logrando Bienestar Ventura County Behavioral Health							
Rapid Integrated Support & Engagement (RISE) Ventura County Behavioral Health							
Network Extension Grants Program Other PEI: WOSMOH							
Suicide Prevention Ventura County Behavioral Health							

COMMUNITY SERVICES AND SUPPORTS (CSS)
Prevention and Early Intervention (PEI)

Program	Number of Participants Served	Cost Per Participant	Target to be served Fiscal Year 2024-2025
Prevention Programs	387,965		
Ignite Conocimiento	93	$2,064	100
Mixteco Indígena Community Organizing Project (MICOP)	140	$1,556	150
Multi-Tiered System of Support (MTSS) – LEA and VCOE	252,656	$7	252,700
Network Expansion Grants – Prevention Programs	256	$1,106	270
One Step a La Vez	241	$1,261	255
Program to Encourage Active, Rewarding Lives for Seniors	225	$3,174	235
Project Esperanza	122	$860	130
Promotoras y Promotores Foundation (PYPF)	207	n/a	220
Tri-County GLAD	42	$1,710	50
Wellness Centers Expansion	89,868	$45	89,900
Early Intervention Programs	656		
COMPASS	18	$100,912	25
Network Expansion Grants – Early Intervention Programs	61	Combined	Combined
Primary Care Program Clinicas del Camino Real, Inc.	305	$2,654	320
Ventura County Power Over Psychosis (VCPOP)	272	$7,599	280
Other PEI Programs	6,323		
Crisis Intervention Team	96	$2,353	105
Diversity Collective	235	$230	245
Logrando Bienestar	1,777	$1,143	1,790
Network Expansion Grants – Other PEI Programs	215	Combined	Combined
Suicide Prevention	4,000	$46	4,100

Fiscal Year 2023-2024 Number of Participants Served by City of Residence[§]

Geographic Area	Number of Participants Served	% of Total
Camarillo	28	2%
Fillmore	268	22%
Moorpark	5	0%
Newbury Park	2	0%
Oak Park	1	0%
Ojai	10	1%
Oxnard	357	30%
Piru	7	1%
Port Hueneme	25	2%
Santa Paula	358	30%
Simi Valley	24	2%
Thousand Oaks	19	2%
Ventura	90	8%
Other	2	0%
Total with available city of residence data:	**1,193**	

[§]City of residence data is not available for Crisis Intervention Training, Multi-Tiered System of Supports VCOE, Multi-Tiered System of Supports LEA.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Prevention and Early Intervention (PEI)

Prevention

The goal of the Prevention component of MHSA is to help counties implement services that promote wellness, foster health, and prevent the suffering that can result from untreated mental illness. In Ventura County, there are 11 programs primarily categorized under Prevention. These programs serve several historically underrepresented populations including Hispanics/Latinos, Transitional Age Youth (TAY), individuals who are Deaf and Hard of Hearing (DHH), and LGBTQ+. Program services vary but include support groups, workshops, trainings, education, and presentations.

Across programs, participants expressed high levels of satisfaction with the services they received. Additionally, programs serving underrepresented groups reached their intended priority population(s). The following pages outline further details about each program's population(s) served, activities and outreach, and participant outcomes.

Prevention programs offer activities to reduce risk factors for and build protective factors against developing a potentially serious mental illness. They may include relapse prevention for individuals in recovery from a serious mental illness. A total of 661,677 participants were served by Prevention programs in FYs 2021-2022, 2022–2023, and 2023-24.

Changes: After numerous and ongoing requests and reports of high need students from the Ventura County Office of Education, VCBH is planning to continue to expand the K-12 Wellness Center program in FY22-23 and 23-24 with additional PEI money. A full report of activities will be reported in next year's annual update.

Prevention Program Descriptions

Mixteco Indígena Community Organization Project (MICOP): Facilitates mental health for the Latino and Indigenous communities through support groups and one-on-one support to manage stress and depression, as well as referrals and links to culturally and linguistically competent mental health providers, and outreach to promote awareness of mental health and existing services.

Multi-Tiered System of Support (MTSS), VCOE and LEA: Provides education and training for school personnel and students, as well as family outreach and engagement to reduce stigma and discrimination about mental illness throughout Ventura County.

Network Expansion Grants - Prevention: 11 of grants provided financial support to time-limited, community-based projects or programs using innovative approaches to reduce mental illness risk and promote well-being in underrepresented populations.

One Step A La Vez: Serves Latino, LGBTQ+, and TAY at risk of homelessness or in the juvenile justice system through outreach, a drop-in center, wraparound wellness, stress and wellness classes, a high school equality club, and LGBTQ+ support groups.

Program to Encourage Active, Rewarding Lives for Seniors (PEARLS): Offers an in-home counseling program for seniors that teaches participants how to manage depression through counseling sessions supported by follow-up phone calls.

Project Esperanza: Offers mental health service assistance, educational and wellness classes, and activities to Hispanic/Latino families in the Santa Paula community.

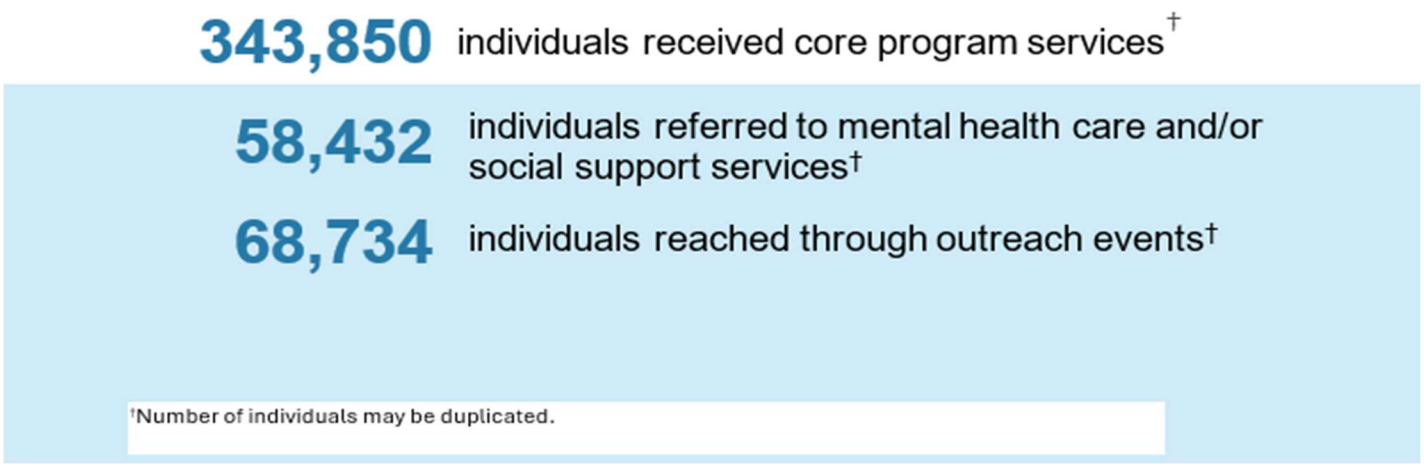
Prevention Program Descriptions

Promoviendo Program (Promotoras y Promotores Foundation [PyPF]): Facilitates mental health for immigrant Latinas/Hispanic women at risk of depression through support groups and one-on-one support to manage stress and depression, as well as referrals and links to culturally and linguistically competent mental health providers, and outreach to promote awareness of mental health and existing services.

Tri-County GLAD: Increases knowledge and awareness of mental health concerns in the Deaf and Hard of Hearing community through outreach, referrals, social media videos, presentations, and workshop.

Wellness Centers Expansion: Provides coordinated health/mental health and other support services to maximize student engagement and success through staff and student training, family engagement activities, screenings, referrals, and early intervention activities.

Wellness Everyday and STAY Media Campaign: Provides prevention, suicide prevention, and coping with trauma messaging via social media campaigns and their website.



COMMUNITY SERVICES AND SUPPORTS (CSS)

Prevention and Early Intervention (PEI)

Prevention

Prevention Programs: Demographics of Participants§

Ethnicity*	(n = 1,050)
Hispanic	88%
Non-Hispanic	26%
More than one ethnicity	<1%
Declined answer: 106	

Age	(n = 1,261)
0–15	33%
16–25	22%
26–59	29%
60+	17%
Declined answer: 2	

Primary Language*	(n = 708)
English	46%
Spanish	56%
Indigenous	3%
Other	20%
Declined answer: 44	

Sex Assigned at Birth	(n = 1,315)
Female	56%
Male	44%
Declined answer: 50	

Sexual Orientation	(n = 1,012)
Bisexual	6%
Gay or Lesbian	2%
Heterosexual or straight	91%
Queer	1%
Questioning or Unsure	1%
Another sexual orientation	1%
Declined answer: 41	

Hispanic Ethnicities^			(n = 924)
Mexican	83%	South American	1%
Central American	2%	Caribbean	0%
Puerto Rican	1%	Another Hispanic	2%

Non-Hispanic Ethnicities^			(n = 126)
African	1%	Asian Indian/South Asian	2%
Cambodian	0%	Chinese	0%
Eastern European	2%	European	16%
Filipino	2%	Japanese	0%
Korean	0%	Middle Eastern	1%
Vietnamese	0%	Another non-Hispanic	2%

Race*	(n = 1,164)
American Indian/Alaska Native	2%
Asian	2%
Black/African American	2%
Hispanic/Latino	73%
Native Hawaiian/Pacific Islander	1%
White	21%
Other	3%
More than one	1%
Declined answer: 15	

Current Gender Identity	(n = 1,124)
Female	69%
Male	28%
Genderqueer	1%
Questioning or Unsure	1%
Transgender	1%
Another gender identity	0%
Declined answer: 3	

City of Residence					(n= 1,228)
Camarillo	3%	Fillmore	22%	Moorpark	0%
Newbury Park	0%	Oak Park	0%	Ojai	3%
Oxnard	25%	Piru	1%	Port Hueneme	2%
Santa Paula	25%	Simi Valley	2%	Thousand Oaks	2%
Ventura	11%	Other	4%		

* Percentages may exceed 100% because participants could choose more than one response option.

§ Demographic data was not collected for MTSS VCOE, MTSS LEA, or Wellness Everyday.

^ Percentages and counts reflect the number of individuals who selected each Hispanic or Non-Hispanic Ethnicity.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Prevention and Early Intervention (PEI)

Early Intervention

The purpose of the Early Intervention component of MHSA is to intervene early in the emergence of symptoms of mental illness to reduce negative outcomes and foster positive recovery and functional outcomes. Ventura County funds four Early Intervention programs that provide crisis stabilization, family support, group and individual therapy, assessment and screening, educational and vocational services, and outreach and education, including the Early Intervention Network Expansion Grants. These Early Intervention services promote wellness, foster health, and prevent suffering that can result from untreated mental illness. Early Intervention programs may include services to family and caregivers of the person with early onset of a mental illness. A total of 1,954 individuals were served by Early Intervention programs in FYS 2021-2022, 2022–2023, and 2023-2024.

Early Intervention Program Descriptions

COMPASS: A short-term residential program for youth ages 12 to 17 transferring from the Crisis Stabilization Unit. Services include individual and family therapy, case management, psychiatric care, medication support and assessment to assist youth and their caregivers in gaining the stability and skills needed to safely return to the community.

Network Expansion Grants – Early Intervention: Four grantees were provided with financial support to time-limited, community-based projects or programs using innovative strategies to support early recovery and functioning among underrepresented populations experiencing mental illness.

Primary Care Program: Provides assessment, individual and group therapy, case management, and care coordination between primary health and behavioral health providers.

Ventura County Power Over Psychosis (VCPOP, formerly EDIPP): Conducts community outreach and education to community members about early warning signs of psychosis; provides a two-year intervention program with services and support including psychiatric assessment, medication management, individual therapy, educational/vocational services, case management, multi-family groups, and peer skill-building groups.

Individuals received core program services†:

656

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COMMUNITY SERVICES AND SUPPORTS (CSS)

Prevention and Early Intervention (PEI)

Early Intervention

Early Intervention Demographics

Ethnicity§	(n = 258)
Hispanic	88%
Non-Hispanic	16%
More than one ethnicity	0%
Declined to answer: 188	

Age§	(n = 651)
0–15	23%
16–25	64%
26–59	27%
60+	2%
Declined answer: 0	

Primary Language	(n = 638)
English	78%
Spanish	28%
Indigenous	2%
Other	0%
Declined answer: 9	

Sex Assigned at Birth	(n = 375)
Female	67%
Male	33%
Declined answer 0	

Sexual Orientation‡	(n = 285)
Bisexual	3%
Gay or Lesbian	1%
Heterosexual or straight	88%
Queer	0%
Questioning or Unsure	1%
Another sexual orientation	7%
Declined answer: 0	

Hispanic Ethnicities^§			(n = 227)
Mexican	65%	South American	0%
Central American	0%	Caribbean	0%
Puerto Rican	6%	Another Hispanic	17%

Non-Hispanic Ethnicities^§			(n = 31)
African	3%	Asian Indian/South Asian	50%
Cambodian	0%	Chinese	0%
Eastern European	0%	European	3%
Filipino	0%	Japanese	0%
Korean	0%	Middle Eastern	0%
Vietnamese	0%	Another non-Hispanic	11%

Race	(n = 491)
American Indian/Alaska Native	1%
Asian	1%
Black/African American	3%
Hispanic/Latino	17%
Native Hawaiian/Pacific Islander	0%
White	44%
Other	32%
More than one	3%
Declined answer: 154	

Current Gender Identity‡	(n = 638)
Female	66%
Male	33%
Genderqueer	0%
Questioning or Unsure	0%
Transgender	1%
Another gender identity	0%
Declined answer: 195	

City of Residence					(n = 1,228)
Camarillo	3%	Fillmore	22%	Moorpark	0%
Newbury Park	0%	Oak Park	0%	Ojai	3%
Oxnard	25%	Piru	1%	Port Hueneme	2%
Santa Paula	25%	Simi Valley	2%	Thousand Oaks	2%
Ventura	11%	Other	4%		

§Age and Ethnicity data were not reported for Primary Care Program.

‡Assigned sex was not reported for COMPASS and VCPOP.

^Percentages and counts reflect the number of individuals who selected each Hispanic or Non-Hispanic Ethnicity.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Prevention and Early Intervention (PEI)

Other PEI Programs

The programs under Other PEI Programs encompass the core program categories of Outreach for Increasing Recognition of Early Signs of Mental Illness, Access and Linkage to Treatment, and Stigma and Discrimination Reduction, as well as Suicide Prevention (optional) and Improving Timely Access to Services for Underserved Populations (optional) programs. All programs in this section focus primarily on training potential first responders—including educators, students, law enforcement personnel, first responders, people with lived experience, and other community members—about ways to recognize and respond effectively to early signs of mental illness. Programs also seek to combat negative perceptions about misinformation and/or stigma associated with having a mental illness or seeking help for mental illness.

A total of 15,776 individuals were served by Other PEI Programs in FYS 2021-2022, 2022–2023, and 2023-2024. Other PEI Programs include the following program categories:

Outreach for Increasing Recognition of Early Signs of Mental Illness programs train potential responders to recognize and respond effectively to early signs of potentially severe and disabling mental illness.

Access and Linkage to Treatment programs connect individuals with severe mental illness to medical care and treatment as early in the onset of these conditions as practicable. These programs focus on screening, assessment, referral, telephone helplines, and mobile response.

Stigma and Discrimination Reduction programs reduce negative attitudes, beliefs, stereotypes, and discrimination toward those with mental illness or seeking mental health services and increase dignity, inclusion, and equity for individuals with mental illness and their families.

Suicide Prevention programs provide organized activities to prevent suicide because of mental illness.

Crisis Intervention Team (CIT): Provides training for first responders to assess and assist people in mental health crisis in a compassionate and effective manner through de-escalation, reduction of use-of-force, and collaboration with consumers, families, the community, and other stakeholders.

Other PEI Program Descriptions

Diversity Collective: Hosts weekly support groups for LGBTQ+ youth, TAY, and their allies, as well as promotes cultural competency and other mental health trainings to schools and agencies to spread awareness of LGBTQ+ mental health needs.

Logrando Bienestar: Helps youth and adults in the Latino community understand the importance of mental and emotional health, with the goal of helping individuals access services for productive and healthy lifestyles.

Rapid Integrated Support & Engagement (RISE): Offers field-based connections to mental health assessment and treatment as well as case management.

VCBH Suicide Prevention: Provides resources to advance awareness and knowledge of suicide and related topics.

6,632 individuals received core program services

COMMUNITY SERVICES AND SUPPORTS (CSS)

Prevention and Early Intervention (PEI)

Other PEI Programs

Other PEI Programs Demographics

Ethnicity*	(n = 1,354)
Hispanic	83%
Non-Hispanic	18%
More than one ethnicity	1%
Declined answer: 800	

Age§	(n = 2,325)
0–15	16%
16–25	25%
26–59	49%
60+	11%
Declined answer: 3	

Primary Language*	(n = 2,229)
English	79%
Spanish	30%
Indigenous	1%
Other	1%
Declined answer: 0	

Sex Assigned at Birth	(n = 313)
Female	48%
Male	52%
Declined answer: 4	

Sexual Orientation§	(n = 455)
Bisexual	4%
Gay or Lesbian	4%
Heterosexual or straight	87%
Queer	3%
Questioning or Unsure	3%
Another sexual orientation	1%
Declined to answer:1726	

Hispanic Ethnicities^			(n = 1,124)
Mexican	69%	South American	2%
Central American	5%	Caribbean	0%
Puerto Rican	1%	Another Hispanic	3%

Non-Hispanic Ethnicities^			(n = 230)
African	1%	Asian Indian/South Asian	0%
Cambodian	0%	Chinese	1%
Eastern European	3%	European	8%
Filipino	2%	Japanese	0%
Korean	0%	Middle Eastern	2%
Vietnamese	0%	Another non-Hispanic	5%

Race*	(n = 1,433)
American Indian/Alaska Native	1%
Asian	3%
Black/African American	2%
Hispanic/Latino	41%
Native Hawaiian/Pacific Islander	0%
White	37%
Other	18%
More than one	7%
Declined answer: 867	

Current Gender Identity§	(n = 1,389)
Female	55%
Male	41%
Genderqueer	1%
Questioning or Unsure	1%
Transgender	2%
Another gender identity	1%
Declined answer: 848	

City of Residence‡					(n = 1,252)
Camarillo	11%	Fillmore	1%	Moorpark	2%
Newbury Park	0%	Oak Park	0%	Ojai	1%
Oxnard	34%	Piru	0%	Port Hueneme	1%
Santa Paula	14%	Simi Valley	4%	Thousand Oaks	2%
Ventura	18%	Other	9%		

Percentages may add to or exceed 100% because participants could choose more than one response option.

§Assigned sex data was not collected from RISE.

^Percentages and counts reflect the number of individuals who selected each Hispanic or Non-Hispanic Ethnicity.

‡City of residence data is not available for CIT and Logrando Bienestar.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Innovation (INN)

Innovation projects can be built to address issues faced by children, transition-age youth, adults, older adults, and family (self-defined), specific neighborhoods, tribal and other communities, counties, or regions. With the inventive nature of innovative projects, there is the potential to impact individuals across all stages and all age groups using a multitude of approaches, including multi-generational practices/approaches. Projects may also initiate, support, and expand collaboration between systems, with a focus on organizations and other practitioners not traditionally defined as a part of mental health care. The following projects have been approved or are in process of achieving approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC) for Ventura County.

The Mental Health Services Act (MHSA) Innovation component provides California with the opportunity to develop and test new, unproven mental health models with the potential to become tomorrow's best practices. The primary purpose of Innovation projects is to achieve at least one of the following:

- Increase access to mental health services to underserved groups, including permanent supportive housing.
- Increase the quality of mental health services, including measurable outcomes.
- Promote interagency and community collaboration related to mental health services, support, or outcomes.
- Increase access to mental health services, including permanent supportive housing.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Innovation (INN)

Highlights for Fiscal Year 2023-2024 Services

Innovation (INN) projects that were approved in fiscal years 2019-2020 through 2023-2024 are outlined below. Planned projects for 2024-2025 have been included but are subject to change as VCBH moves through the Community Program Planning Process (CPPP).

Current Innovation Projects	Fiscal Years	Purpose	Status
FSP Multi County Innovation Project	2019- 2024	An innovative opportunity for a diverse group of counties to develop and implement new data-driven strategies to better coordinate and improve FSP service delivery, operations, data collection, and evaluation.	Final Report in Appendix
Semi-Statewide Enterprise Health Record (EHR) Innovation	2023-2027	California counties have joined together to envision an enterprise solution where the EHR goes far beyond its original purpose as a claiming system to a tool that helps counties manage the diverse needs of their population. The counties participating in the Semi-Statewide EHR have reimagined what is possible from the typical EHR system.	In process
M.A.S.H. Senior Support to Reduce Homelessness	2022-2027	To provide creative case management, therapeutic, and material support to enrolled seniors at risk of losing their housing due to fiscal, cognitive, or physical restrictions.	In process
Mobile Mental Health Van Project	2025-2028	To provide reliable, flexible physical and mental health care to unserved and underserved individuals in Ventura County, regardless of insurance or legal status.	Launch date 2024-2025
Early Psyhcosis Statewide Learning Collective Project	2025- 2028	Led by UC Davis in partnership with UC San Francisco, UC San Diego, University of Calgary, and a number of California counties will bring consumer-level data to clinicians, allow programs to learn from each other, and position the state to participate in the development of a national network to inform and improve care for individuals with early psychosis.	Launch date 24-25

Planned Projects	Fiscal Years	Purpose	Status
Veteran Mentorship Innovation Project	Seeking approval 2024-2025	The Veteran Mentor Innovation Project will focus on assisting veterans and first responders who are transitioning from service to civilian life in Ventura County through a mentorship program.	
Collaborative Care Model for Youth	Seeking approval 2024-2025	The program will pilot the Collaborative Care Model and Behavioral Health Integration models to integrate care by treating both the mental and physical needs of children, adolescents and youth adults to improve patient outcomes and satisfaction at a lower cost.	

COMMUNITY SERVICES AND SUPPORTS (CSS)
Innovation (INN)
Multi-County Full-Service Partnership (FSP) Project

Program Description

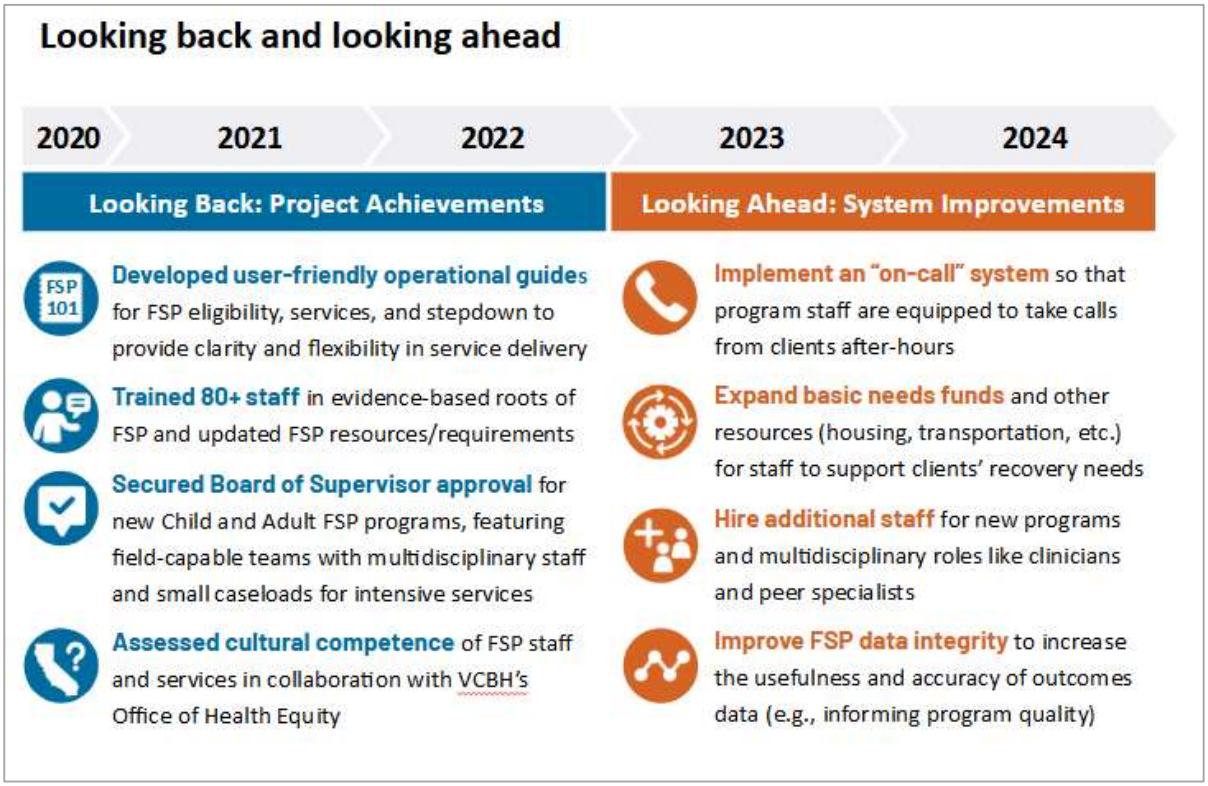
Counties throughout the state and FSP providers identified two barriers to improving and delivering on the "whatever it takes" goal of FSP. The first barrier is a *lack of information* about which components of FSP programs deliver the greatest impact. The second barrier is *inconsistent FSP implementation*. FSP's "whatever it takes" spirit has allowed necessary flexibility to adapt the FSP model for a wide variety of populations and unique local contexts. At the same time, this flexibility inhibits meaningful comparison and a unified standard of care across the state.

The project began in 2020 to respond to these challenges by reframing FSP programs around meaningful outcomes and the partner (client) experience. This multi-county project represents an innovative opportunity for a diverse group of participating counties (Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura) to develop and implement new data-driven strategies to improve coordination of FSP service delivery, operations, data collection, and evaluation. Through participation in the multi-county project, participating counties have worked to implement new data-informed strategies to program design and continue improvement for their FSP programs. Ventura worked additionally on several county-specific implementation goals with the support of the Third Sector and RAND's evaluation technical assistance.

Program Developments

The project formally ended in June 2024. VCBH continues to work on the system improvements identified in the extension plan. Both the youth and the dedicated Adult FSP programs were launched successfully. The nationwide workforce shortage had delayed program implementation for several months however both programs are operating at full capacity as of June 2024. Other aspects of the program continue to move forward.

The project's final report is in the appendix of the report.



Program Developments

The Mobile Mental Health program will provide reliable, flexible physical and mental health services to unserved and underserved individuals in Ventura County, regardless of insurance or legal status. The direct and accessible approach to health care can positively affect stigma, emergency room use, and client engagement. The program is designed to deliver quality, quick, and consistent walk-in mobile mental health therapy to residents who have recently been in crisis, live in underserved areas, or identify as being part of underserved communities.

The vehicle order was placed in Fiscal Year 2021-2022, but due to COVID-19 supply chain issues was not delivered until Fiscal Year 2023-2024 and is not scheduled to have the modification completed until 2024-25. One RFP was completed in Fiscal Year 2023-2024 however the awarded contractor declined to move forward on the award. VCBH's Critical Care and Navigation team will now launch the program in Fiscal Year 2024-2025.

Activities	Date/Time Period
Project idea developed through CPP process	Fall of 2020 and Winter of 2021
Project approved by the Board of Supervisors	May 11, 2021
Project approved by the MHSOAC	May 27, 2021
The project launch goal	October, 2024

COMMUNITY SERVICES AND SUPPORTS (CSS)

Innovation (INN)

Managing Assets for Security and Health (M.A.S.H.) Senior Supports for Housing Stability

The purpose of the Managing Assets for Security and Health (MASH) program is to provide multiple key supports for seniors at risk of homelessness. The program began on October 1, 2022, and is scheduled to end June 30, 2027. The project's goal is to provide creative case management, therapeutic, and material support to enrolled seniors at risk of losing their housing due to fiscal, cognitive, or physical restrictions. By assigning and monitoring volunteers to work with homebound seniors, the clients will build a trusting relationship with the organization and be more likely to engage in a housing resource plan to include essential services and concrete resources as needed. The participants will be able to explore multiple solutions to their housing situation over time, increasing the chances for success in a new placement. By matching trained specialty peer volunteers with homebound seniors who can help identify and work with those seniors who are in jeopardy of losing their current housing.

Programming Updates

A challenge has been that some clients have reservations about consenting to data sharing.

MASH Enrollment and Demographics

A total of 302 adults have been enrolled in MASH since FY 2022-2023 and completed the initial screening survey. Most clients were White women (79%, respectively), had private insurance (77%) and resided in Ventura (31%). A full description of demographics is included in the appendix report. There were 106 clients who completed the initial BGS scored in Tier 1, indicating they were "thriving" and did not need further assessment. Of the remaining 196 clients eligible for follow-up with the next MASH assessment survey, 32 clients completed the initial R&R survey. Reasons eligible clients did not complete the R&R survey included not being able to be reached by program staff and declining to complete the survey.

Of the 32 clients who completed the initial R&R assessment, no clients fell into Tier 4 or crisis. For 15 clients, cases were stalled and eventually closed before recommendations could be presented due to being nonresponsive (i.e., unable to reach the client), noncompliant (i.e., canceling multiple appointments or unwilling to share necessary financial information), or no longer interested in MASH services. A total of 36 clients have been discharged from MASH. Four clients completed exit BGS and R&R surveys after discharge. All these clients were English-speaking women who were experiencing a disability while half identified racially as White. Three of these clients completed interviews. Further detail on these responses are outlined in the appendix report.

COMMUNITY SERVICES AND SUPPORTS (CSS)
Innovation (INN)
Semi Statewide Electronic Health Record INN Project

Ventura County's highest priorities are client care and addressing the needs of the community. VCBH plans to meet these priorities by joining CalMHSA in creating a new Semi-Statewide Enterprise Health Record, using Streamline Healthcare's SmartCare platform, to do both. The new EHR will be more person and provider centered; services can be enhanced by decreasing the amount of time (estimated 30%) providers are required to document. The project will include a robust process of input from participant counties to ensure the system will allow VCBH stakeholder feedback to be incorporated and for staff to have additional time to provide enhanced services to the community. This multi-county collaborative will capitalize on the strength, knowledge, and experiences of over twenty (20+) counties in formulating a new EHR. The new EHR will meet the new CalAIM standards and will quickly adapt to the ever-changing State requirements. Additionally, it will allow staff to collect and report on meaningful outcomes and provide tools for direct service staff that enhance rather than hinder care to the clients they serve.

Programming Updates

Throughout FY 2023-24, Ventura County staff worked diligently to support the rollout of SmartCare for both VCBH and CBO teams. By late summer 2023, all staff had completed orientation to the new EHR system and were receiving regular updates as the platform evolved to meet county requirements and DHCS specifications. Over the first year of implementation, staff across all levels grew more proficient with the system, adapting to its workflows and functionality.

To enhance onboarding and improve the user experience, the EHR team collaborated closely with Office Assistants, Clinicians, Prescribers, and Nurses by shadowing them during their daily operations. This hands-on approach allowed the team to identify workflow inefficiencies and informed the creation of a comprehensive training program. Mandatory in-person training was required for all new users, while the enhanced training program was offered as an optional resource for existing users. Many staff members participated, leveraging the opportunity to deepen their proficiency with the system and streamline their workflows. This approach, while effective, was costly and resulted in high staff costs during implementation which the County addressed in year two.

State reporting continues to be challenging and lags behind the timeline thus delaying the departments' ability to submit timely FSP data to the state.

A full update report can be found in the Appendix.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Workforce Education and Training (WET)

Workforce Education and Training component includes education and training programs and activities for prospective and current Public Mental Health System employees, contractors and volunteers. Refer to CCR, Title 9, Section 3810 - General Workforce Education and Training Requirements for information regarding how MHSA funds can and cannot be used to support WET programs.

COMMUNITY SERVICES AND SUPPORTS (CSS)
Workforce Education and Training (WET)
Trainings

Bringing Culture into our Practice	3 hours, specialty topics vary and are offered annually
This 3-hour interactive training will lead the participants through fundamental strategies necessary in the investigation and remediation of issues of equity, culture, and diversity from a relationship-based perspective. Attendees will reflect on their social identities as related to areas of privilege and marginalization. We will define and explore the role of culture, intersectionality, implicit bias, as related to client engagement and service delivery. Attendees will be provided with practical strategies to begin a curious conversation with clients related to culture, family history, and micro-aggression by systems.	
Presenter(s)	**Dates(s)**
Barbara Stroud, PhD	03/24/2024

CEOVC - Developing Cultural Competency & Inclusion	Self-paced (approx. 2 hrs.)
Mandatory class for DEI for all County of Ventura employees, taken biannually.	
Presenter(s)	**Dates(s)**
County of Ventura	FY23-24

Community Resiliency Model (CRM): Introduction	3 hours, Offered bi-annually
The Community Resiliency Model® (CRM) of the Trauma Resource Institute trains clinicians and non-clinicians to not only help themselves but to share simple wellness skills with their community. The primary focus of this training is to learn simple biologically based skills, based upon current science, to help individuals and communities regain balance in body, mind, and spirit. CRM skills help individuals understand their nervous system and learn to track sensations connected to their own well-being, which CRM calls the “Resilient Zone.” CRM’s goal is to help create “trauma-informed” and “resiliency-informed” communities that share a common understanding of the impact of trauma and chronic stress on the nervous system and how resiliency can be restored or increased using this skills-based approach. CRM has been used worldwide. El Modelo de Resiliencia Comunitaria (Community Resiliency Model® (CRM) del Trauma Resource Institute capacita a profesionales y no profesionales no solo para ayudarse a sí mismos sino también para compartir habilidades simples de bienestar con su comunidad. El enfoque principal de esta capacitación es aprender habilidades biológicas simples, basadas en la ciencia actual, para ayudar a las personas y comunidades a recuperar el equilibrio en cuerpo, mente y espíritu. Las habilidades de CRM ayudan a las personas a comprender su sistema nervioso y aprender a rastrear las sensaciones relacionadas con su propio bienestar, lo que CRM llama la "Zona Resiliente". El objetivo de CRM es ayudar a crear comunidades “informadas sobre el trauma” y “informadas sobre la resiliencia” que compartan una comprensión común del impacto del trauma y el estrés crónico en el sistema nervioso y cómo se puede restaurar o aumentar la resiliencia utilizando este enfoque basado en habilidades. CRM se ha utilizado en todo el mundo.	
Presenter(s)	**Dates(s)**
Joy Chudzynski PsyD	12/04/2023
Joy Chudzynski PsyD	06/17/2024 (with Spanish interpretation)
Joy Chudzynski PsyD	06/24/2024 (with Spanish interpretation)

COMMUNITY SERVICES AND SUPPORTS (CSS)

Workforce Education and Training (WET)

Trainings

Community Resiliency Model (CRM): Skills	9 hours, offered annually
The Community Resiliency Model® (CRM) is a set of wellness skills one can learn and use to help regulate their nervous system. CRM aims to teach people about how their nervous system works, how it responds to stress, and how it can become dysregulated. CRM is a collection of six wellness skills that can be used for self-care, that restore balance to the mind, body, and spirit. CRM focuses on helping people learn to connect their minds and bodies as they learn to pay attention to sensations "on the inside of their body". When people learn how to tell the difference between sensations of distress and wellbeing, resiliency can expand by learning simple wellness skills. The result is feeling greater balance in mind, body and spirit. When we are balanced, we are better able to function at our highest capacity.	
Presenter(s)	**Dates(s)**
Joy Chudzynski PsyD	03/13/2024
Cultural Core Competencies	**self-paced (approx. 2 hrs.)**
Southern Counties Regional Partnership (SCRP) Core Competencies Project provides the Core Competencies and associated Knowledge, and Abilities (KSAs) considered to be essential performance criteria for collaborative behavioral health service providers supporting the continued excellence on the quality of care provided to individual, family member, and stakeholders serv ed by the SCRP counties.	
Presenter(s)	**Dates(s)**
VCBH/SCRP Project	FY23-24
LGBTQ+ RISE Part I Introduction to SOGIE and Permanency	3 hours, available 8 times per year
This course is evidence-informed to help all staff gain working knowledge of permanency and childhood development. Learn about LGBTQ+ identities and terminology regarding sexual orientation, gender identify and expression SOGIE. Participants will be taught to identify biases faced by the LGBTQ+ community. Learning Objectives include Demonstrate understanding of permanency and childhood development for the LGBTQ+ population; Use appropriate language and terminology relating to LGBTQ+ identities and SOGIE; Demonstrate ability to identify biases faced by the LGBTQ+ community.	
Location and Presenter(s)	**Date**
Los Angelas LGBT Center - Ramos, Nako; Garcia, Keilani	11/16/2023
Los Angelas LGBT Center - Ramos, Nako; Garcia, Keilani	12/13/2023 (AM)
Los Angelas LGBT Center - Ramos, Nako; Garcia, Keilani	12/13/2023 (PM)
Los Angelas LGBT Center - Ramos, Nako; Garcia, Keilani	12/14/2023 (AM)
Los Angelas LGBT Center - Ramos, Nako; Garcia, Keilani	12/14/2023 (PM)
Los Angelas LGBT Center - Ramos, Nako	02/08/2024
Los Angelas LGBT Center - Ramos, Nako	02/14/2024
Los Angelas LGBT Center - Bustamante, Ariel	05/21/2024

LGBTQ+ RISE Part II	**3 hours, available 4 times per year**
This course is designed to help non-clinical administrative staff to gain working knowledge of biases in daily interactions for LGBTQ+ clients. Learn about risk and protective factors in healthcare spaces. How to create and maintain trustful, safe, spaces while serving LGBTQ+ clients.	
Location and Presenter(s)	**Date**
Los Angelas LGBT Center - Ramos, Nako; Garcia, Keilani	11/16/2023
Los Angelas LGBT Center - Ramos, Nako	1/11/2024 (AM)
Los Angelas LGBT Center - Ramos, Nako	1/11/2024 (PM)
Los Angelas LGBT Center - Bustamante, Ariel, Ramirez-Mercado, Josh	5/28/2024
Los Angelas LGBT Center - Ramos, Nako	01/25/2024 (AM)
Los Angelas LGBT Center - Ramos, Nako; Garcia, Keilani	01/25/2024 (PM)
Mental Health First Aid (MHFA) - County	**7 hours, offered 6 times annually**
Similar to how CPR training helps you assist someone in cardiac arrest, MHFA teaches you how to identify, understand, and respond to signs of mental illnesses and substance use disorders. The training gives you skills to provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis.	
Location and Presenter(s)	**Date**
VCBH - Munoz, April M., Aguilar, Norma A.	09/21/2023 (for adults)
VCBH - Aguilar, Norma A. and Julie Ehret, LCSW	03/25/2024 (for adults)
VCBH - Julie Ehret, LCSW and Aguilar, Norma A.	04/16/2024 (for adults)
VCBH - Dougherty, Jennifer, LCSW and Julie Ehret, LCSW	05/09/2024 (for adults)
VCBH - Jennifer Dougherty, LCSW	05/02/2024 (for youth)
Real Colors	**4 Hours, offered to programs annually**
Real Colors® is a unique four color personality assessment and workshop designed to be entertaining and user-friendly. The four color personality assessment is based on the premise that you can take left-brain (linear) information, and turn it into an exciting, interactive right-brain experience. The right brain style uses colors, pictures, and interactive activities to hook the participants. It allows participants to learn a great deal of information more quickly. They leave the four hour workshop with tools they can use and apply to their own life. Through right and left brain activities, small group interaction, and large group discussion, participants take an active role in learning. A portion of the workshop involves the participants teaching each other. This not only establishes new information for the participants, but in fact adds to the instrument's validity.	
Location and Presenter(s)	**Date**
County of Ventura - Hendrickson, Gina Rae	01/03/2024
County of Ventura - Hendrickson, Gina Rae	01/09/2024
County of Ventura - Hendrickson, Gina Rae	04/10/2024

COMMUNITY SERVICES AND SUPPORTS (CSS)

Workforce Education and Training (WET)

Trainings

Special Topics in Suicide: LGBTQ+, Older Adults, Support for Survivors of Suicide Loss	**6 hours, specialty topic (specialty topics vary and are offered annually)**
In this workshop participants will learn techniques and obtain tools for assessing suicidal risk among LGBTQ+ and Older Adults, with cultural awareness, humility, and sensitivity. They will learn prevention and resilience strategies to reduce risk. Exacerbating and mitigating factors and theories/goals of grief work to support survivors of suicide loss will be explored. External and internal resources to support these special populations will be discussed and self-care for clinicians to protect them from burnout with these populations will also be discussed.	
Location and Presenter(s)	**Date**
SCRP sponsored: Deborah Silveria, PhD	11/17/2023

Trial-Based Cognitive Therapy: Expanding CBT Tools (Spanish)	**6 hours, offered annually**
Trial-Based Cognitive Therapy (TBCT) is an active therapeutic approach based on Cognitive-Behavior Therapy (CBT) that aims to help clients recognize and modify their situationally based automatic thoughts and unhelpful beliefs, including core beliefs (CBs). TBCT uses a three-level, three-phase case formulation approach with unique conceptualization and techniques to modify clients' cognitions. Attendees of this course will observe Dr. Reis de Oliveira implement TBCT's main innovative techniques, including: • The TBCT Conceptualization Diagram provides a framework for understanding and addressing three levels of cognitive processing: automatic thoughts, underlying assumptions, and CBs. • The Intrapersonal Thought-Record (Intra-TR) is a tool used to guide the patient in identifying and modifying their negative automatic thoughts. By systematically answering specific questions, the patient can gain a more balanced and accurate perspective on the situation and develop more adaptive and helpful thoughts. • The Participation Grid (PG) is a narrative exposure technique that helps the patient transform guilt into participation and ultimately responsibility through progressive exposure to the guilt-provoking situation. The therapist then helps the patient transform guilt into responsibility, now in a different context, related to the patient's desired values and commitment. • The Trial-Based Thought Record (TBTR), which engages individuals in a courtroom metaphor, encouraging them to challenge and modify CBs and reduce emotional distress. La Terapia Cognitiva Procesal (TCP) es un enfoque terapéutico activo basado en la Terapia Cognitivo-Conductual (TCC) que busca ayudar a los clientes a reconocer y modificar sus pensamientos automáticos situacionales y creencias disfuncionales, incluyendo las creencias nucleares (CN). La TCP utiliza un enfoque de formulación de casos en tres niveles y tres fases con una conceptualización y técnicas únicas para modificar las cogniciones de los clientes. Los asistentes a este curso observarán al Dr. de Oliveira implementar las principales técnicas innovadoras de la TCP, incluyendo: • El Diagrama de Conceptualización de la TCP, que proporciona un marco para entender y abordar tres niveles de procesamiento cognitivo: pensamientos automáticos, supuestos subyacentes y CN. • El Registro de Pensamientos Intrapersonal (RP-Intra) es una herramienta utilizada para guiar al paciente en la identificación y modificación de sus pensamientos automáticos negativos. Al responder sistemáticamente preguntas específicas, el paciente puede obtener una perspectiva más equilibrada y precisa de la situación y desarrollar pensamientos más adaptativos y útiles. • La Rejilla de Participación (RP) es una técnica de exposición narrativa que ayuda al paciente a transformar la culpa en participación y, finalmente, en responsabilidad a través de la exposición progresiva a la situación que provoca culpa. El terapeuta entonces ayuda al paciente a transformar la culpa en responsabilidad, ahora en un contexto diferente, relacionado con los valores y compromisos deseados del paciente. • El Registro de Pensamientos Basado en el Juicio (RPBJ), que involucra a los individuos en una metáfora de un juicio, alentándolos a desafiar y modificar las CN y reducir el sufrimiento emocional.	
Location and Presenter(s)	**Date**
Academy of Cognitive Therapy - Reis De Oliveira, Irismar	05/29/2024

COMMUNITY SERVICES AND SUPPORTS (CSS)

Workforce Education and Training (WET)

Trainings

Use of Interpreter Training	**1.5 hours, annual for everyone**
This training will provide guidance on Working with Interpreters in a Mental Health Setting. The following topics will be discussed: 1. Latinx, Language Access, & COVID-19 2. The importance of trained interpreters 3. Common practices of trained interpreters 4. Strategies for working with trained and untrained interpreters 5. Considerations for mental health settings Click on link to watch the video. It is 1 hour and 32 minutes long.	
Location and Presenter(s)	**Date**
Cecily Rodriguez, MPA	FY23-24
Seeking Safety - Introductory Session	**6 hours, offered annually**
This training is an evidence-based model for trauma and/or substance abuse. By the end of the training, participants can implement Seeking Safety in their setting if they choose to. Seeking Safety teaches present focused coping skills to help clients attain safety in their lives. It is highly flexible and can be conducted in any setting by a wide range of counselors and also peers. There are 25 treatment topics, each representing a safe coping skill relevant to both trauma and/or substance abuse, such as “Asking for Help”, “Creating Meaning”, “Compassion”, and “Healing from Anger”. Seeking Safety strives to increase hope through emphasis on ideals; it offers exercises, emotionally evocative language, and quotations to engage patients; and provides concrete strategies to build recovery skills. In this training we cover (a) background on trauma and substance abuse (rates, presentation, models and stages of treatment, clinical challenges); and (b) overview of Seeking Safety including its evidence base; and (c) clinical implementation, such as use of the model with specific populations.	
Location and Presenter(s)	**Date**
Gabriella Grant	10/13/2023
Advanced Seeking Safety	**6 hours, offered bi-annually at minimum**
This training goes beyond the basic Seeking Safety training. It focuses on implementation methods to improve engagement and high-quality delivery of the model. It offers a brief refresher on the model; adaptation of Seeking Safety for different populations; deepening the approach to trauma; therapeutic Seeking Safety games; responding to challenging clients; fidelity; and how to sustain the model. In addition, there is ample opportunity for attendees to share their successes, obstacles and case examples. If desired, an attendee can conduct a mini roleplay of a session and obtain constructive feedback based on the Seeking Safety fidelity scale (if you would like to volunteer for this excellent learning opportunity email training@treatment-innovations.org). The webinar is highly interactive with a variety of clinical exercises. Attendees can also email specific questions and clinical scenarios in advance they would like to discuss.	
Location and Presenter(s)	**Dates**
SCRP: Treatment Innovations/Summer Krause, LPC, CADCIII	02/28/2024
SCRP: Treatment Innovations/Summer Krause, LPC, CADCIII	04/24/2024

Co-occurring Disorders	**6 hours, twice annually**

This course will prepare participants for how to provide integrated assessments and treatment for clients who present with both psychiatric and substance use disorders and why evidence-based integrated strategies result in more effective treatment for both disorders. Examples will be provided of how the disorders interact and why this interaction may result in a confusing diagnostic presentation. The course will discuss assessment and treatment procedures for examining the interactive relationship of the disorders from a client-centered perspective.

The course will explain the relationship between stress/trauma and substance use and the neuroanatomical and neurobiological factors related to this interaction. The long-term impact of adverse childhood experiences on both disorders will be discussed. Medication Assisted Treatment and the principles of Harm Reduction will be addressed. The course will also cover the process of Recovery Management as well as Recurrence of Substance Use. The course will conclude with an examination of "self-help" groups and how/why client participation in such groups can enhance professional interventions.

Location and Presenter(s)	**Dates**
VCBH - Linda Gertson, PhD	01/30/2024
VCBH - Linda Gertson, PhD	02/07/2024

Crisis Assessment	**1.5 hours, offered at minimum annually**

This training will review how to initiate, coordinate, and complete a crisis evaluation. This training will cover assessment considerations and review case examples. Participants will learn how to analyze and assess appropriateness of potential outcomes in crisis evaluations, such as, safety planning, voluntary hospitalization, and involuntary hospitalization. Participants will be able to explain how to assess staff safety, client safety and community safety when responding to crisis evaluations. This training will cover utilization of referrals and collaborating with community partners.

Location and Presenter(s)	**Dates**
VCBH: Estefania Elizalde, LCSW	01/23/2024
VCBH: Estefania Elizalde, LCSW	06/26/2024

DSM 5TR Update: What Every Clinician Needs to Know	**1.5 hours, offered at minimum annually**

Released in March 2022, the DSM-5 Text Revision (TR) includes a handful of major changes along with numerous clarifications to improve your ability to both diagnose and document crisis issues. Join Dr. Diane Gehart as she explains these changes in easy-to-understand language. Changes include discussion of Prolonged Grief Disorder, new codes for suicide and self-harming behaviors, reinsertion of NOS Mood Disorder, and significant changes to language diagnostic criteria.

Location and Presenter(s)	**Dates**
SCRP: Diane Gehart, Ph.D.	09/19/2023
SCRP: Diane Gehart, Ph.D.	09/21/2023
SCRP: Diane Gehart, Ph.D.	09/28/2023
SCRP: Diane Gehart, Ph.D.	10/05/2023
SCRP: Diane Gehart, Ph.D.	10/10/2023

COMMUNITY SERVICES AND SUPPORTS (CSS)

Workforce Education and Training (WET)

SCRP Retention Strategies

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

A second Southern Counties Regional Partnership (SCRP) was funded in 2021. The Partnership represents 10 counties committed to expanding Southern California's public behavioral health workforce. This fund has approximately 11 million dollars and 4 million in "matching" funds from all SCRP counties by 2024, making available 15 million to spend in approximately five years. In fiscal year 23-24, Retention Strategies Funding supported:

Retention approaches focus on staff training in evidence-based practices (EBPs) and in staff wellness programs. This includes training in such topics as Trauma Informed Care, Cognitive Behavioral Therapy, Seeking Safety, Motivational Interviewing, and other EBP's. In addition to this professional development training, staff are also provided with staff wellness programs focused on reducing job stress and a reduction of job burnout. These include training and programs in self-care, trauma informed care, and vicarious trauma strategies. Also, in response to the Community Mental Health Needs Assessment, SCRP funding continued to offer Suicide Prevention training.

Target is minimum 10 SCRP funded trainings (minimum 100 staff). Actual: 21 Trainings funded trainings (314 staff in attendance - waiting for attendance numbers to 7 of the 21 trainings)

Consultation Calls in Seeking Safety, a trauma informed integrated care EBP began in January 2023 - the goal was to have a minimum of 10 staff participate monthly. The goal was not reached, the Consultation Calls have been discontinued; however, 34 (pending attendance records for 3 Consultation opportunities) staff attended during the 23-24 fiscal year.

In addition to the individual regional training, the retention strategy also includes an annual conference for 150 attendees each year that addresses strategies for the enhancement of clinical supervision and whole person integrated care.

Three conferences were held this fiscal year:

Clinical Supervisors Conference October 23-25, 2023.

Elevate: A Conference to Educate, Engage and Enrich Clinical Supervisors -------- 17 staff attended

- Review best clinical supervision practices in a collaborative environment
- Improve skills and integrate strategies for providing excellent clinical supervision
- Increase resources and apply current research regarding clinical supervision
- Develop a sense of community and collaborative opportunities with clinical supervisors across the SCRP counties.

Whole Person Integrated Care Conference -- March 26-27, 2024 ---------- 22 Staff attended

An Opportunity for Mental Health Professionals to:

- Learn whole person integrated interventions that address the complex needs of vulnerable populations
- Acquire strategies to address health equity, identify disparities and barriers to care
- Develop new insights into underlying biopsychosocial factors that contribute to mental health disorders and recovery

International Interdisciplinary Conference on Clinical Supervision (IICCS) -- June 13 and 14, 2024 – 8 Staff attended

COMMUNITY SERVICES AND SUPPORTS (CSS)

Workforce Education and Training (WET)

SCRP Retention Strategies

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The VCBH Training Plan included many training courses which addressed the needs of the CMHNA. There was an emphasis on providing quality training to the workforce focused on a variety of issues, including training which addresses trauma, risk assessment, diagnosis, suicide prevention, depression and anxiety, underserved populations and more. In addition, conference topics supported whole person's treatment, identified as a need in the CMHNA as well as growing the profession through Clinical Supervision training.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Workforce Education and Training (WET)

Mental Health Career Pathway

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

Mental Health Services Act Workforce Education and Training (WET) programs currently include participation in the 1) Mentored Internship Program (MIP) grant for two sites and 2) Southern California Regional Partnership.

VCBH is honored to be an awardee of The Mentored Internship Program (MIP) grant or 2 VCBH sites over 2 grant cycles. The MIP grant is a "component of the California Department of Health Care Services (DHCS) Behavioral Health Workforce Development (BHWD)" efforts with a primary goal to enhance the professional development to help meet California's urgent need for a diverse BH workforce and expand California's future BH workforce, developing ongoing partnerships between BH systems and local educational institutions.
The 2023-2024 Academic Year focused on improving the Internship Program structure to establish standardized clinical experiences and strengthen a mentorship supervision model through the MIP grant process. Educational partnerships were increased, students' onboarding protocols were improved and foundational training for students were identified. Educational partnerships were increased, student's onboarding protocols were improved and foundational training for students were identified.

A second Southern Counties Regional Partnership (SCRP) was funded in 2021. The Partnership represents 10 counties committed to expanding Southern California's public behavioral health workforce. This fund has approximately 11 million dollars and 4 million in "matching" funds from all SCRP counties by 2024, making available 15 million to spend in approximately five years. In fiscal year 23-24, Pipeline Program funded:
Three undergraduate stipends ($3000 each) to Bachelor level undergraduate behavioral science students completing their Mental Health Associate internship.

Funds continue to be available to award 25 peer stipends at $500 each - contract with vendor was recently modified to allow flexibility in the use of this $12,500 in funding to best support VCBH Peer needs, expanding the usability of these funds for peer training needs.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The CMHNA emphasizes the need to grow and train the behavioral health workforce. Stipends encourage students interested in a career in behavioral health work to consider a career in public service, offering them a paid opportunity to be exposed to the field while receiving quality training at VCBH, including foundational evidence based practice training. Further, a stipend attracts bi-lingual Spanish students to chose VCBH as a placement. In Fy23-24, VCBH hosted 4 undergraduate bi-lingual Spanish Speaking students, each receiving either a MIP or SCRP funded stipend.

As more peers enter the workforce, SCRP funding will be able to be utilized to support peer specific training needs.
In addition, further supporting pipeline development, SCRP funds provided career pathway information material in FY22-23 which continued to be distributed to our local high school districts in FY23-24. As recommended in the CMHNA, Career pathway information was offered in various formats: posters, pamphlets, e-version.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Workforce Education and Training (WET)

Mental Health Loan Repayment

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The SCRP funded Loan Repayment Program aims to provide financial assistance to employees in high need and hard-to-fill positions, as designated by each County. Applicants apply for the program through the HCAi centralized application and are scored by CalMHSA on an objective approach following the model of the MHLAP. The information is reviewed by each individual county to confirm eligibility. Eligibility for the program is based on individuals that are regular full-time employees, with an emphasis on selecting applicants who enhance and the diversity within the public behavioral health system of care (PBHS). Recipients are required to complete a work obligation of 1 year and to complete an annual follow-up survey for up to three years regarding employment status and satisfaction within the PBHS. VCBH budgeted for 52 $7,500 awards.

30 Awards were used by the end of FY23-24 with 22 potential awardees identified for the 3rd and final cohort of awards and service agreements being sent out to each potential awardee. Awardees from the 1st cycle (FY 21/22) completed their work agreement in August 2023 and received their loan repayment award towards their educational loans. Awardees for the 2nd cycle (FY 22/23) will have completed their work agreement in August 2024 and funding will be issued at that time towards their educational loans.

Key challenges included having a large number of applicants such that not every applicant could be awarded as well a certain number of Awardees not fulfilling requirements thus ever changing the number of awards available for each cohort. Some staff left after the one year work obligation; thus, suggesting a retention plan may need a longer work obligation.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The CMHNA emphasizes the importance of a quality Educated and trained Workforce as well as a diverse workforce. Loan Repayment is a retention effort that supports keeping staff which we have invested in training for a minimum of 2 years - they must be passed probation to qualify to apply (1 year) and then, if chosen, must complete a year of service before they can accept the $7,500 award.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Workforce Education and Training (WET)

Internship Programs

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

VCBH continues to be invested in workforce development efforts. In fiscal year 2023-2024, VCBH hosted 11 undergraduate students and 21 graduate level students for their school related field experience. Stipends provide financial support to graduate students completing a clinical degree while they are completing their required clinical training within the public behavioral health system. This financial incentive program has provided a valuable incentive to graduate students to encourage gaining knowledge and experience within the public behavioral health system. Ideally, through this exposure, it will inspire new graduates to continue their professional development by pursuing employment in the public behavioral health system after they have had their exposure.

MIP funding was available to support student stipends in fiscal years 2022-2023 and 2023-2024. SCRP stipend funds supplemented stipends in 2023-2024. VCBH awarded $223,748.60 in MIP stipend funding to support: 11 undergraduate students and 17 graduate students. SCRP stipends awarded $6,0000 to 6 graduate students (utilizing $36,000 of stipend budget) and $3,000 to 3 MHA students (utilizing $9,000) of pipeline budget.

Key Challenges: Some Student did not receive a stipend due to 1) not being placed at a MIP site 2) not applying for an HCAi SCRP funded stipend 3) not meeting HCAi criteria for SCRP funded stipends (e.g. having received a separate HCAi award).

MIP funding ends in December 2024 and SCRP Stipend funds must be expended by June 20, 2025; thus, an alternate funding stream must be identified in order to keep this valuable workforce development tool.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The CMHNA emphasizes the importance of a quality Educated and trained Workforce as well as a diverse workforce. The Internship Stipends encourage students interested in a career in behavioral health work to consider a career in public service, offering them a paid opportunity to be exposed to the field while receiving quality training at VCBH, including foundational evidence-based practice training. Further, a stipend attracts bi-lingual Spanish students to choose VCBH as a placement. In FY23-24, VCBH hosted 8 graduate level and 4 undergraduate bi-lingual Spanish Speaking students.

Include examples of notable community impact.

The Department has since hired five of the FY23-24 Interns.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Workforce Education and Training (WET)

Training Programs

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The Training Team added a Program Manager. The Team now consists of 1 manager, 1 BHC, 1 Programs Administrator and 2 Administrative Assistants.

Key challenges: With increasing demand, thoughts to expand staffing may need to be considered. Previous Training Plan Managers: 1) Clinical Training and internships and 2) Required Trainings.

Staff supports training development, assignment, monitoring and reporting, ensuring staff serving underserved groups have access and comply with the required training. Further, a structure to support Mental Health First (MHFA) training has been developed and received continued support. Mental Health First Aid Training is a nationally respected evidenced based practice "skills-based training course that teaches participants to identify, understand and respond to mental health and substance use challenges."

SCRP funded costs for Seeking Safety Training, which was offered to address the long identified need for co-occurring disorders. Seeking Safety, per SAMSHA, is "an evidence-based treatment that helps people with trauma, posttraumatic stress disorder, and substance misuse."

Describe how this program addresses the community issues identified during the County's Community Program Planning Process issues, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

Mental Health First Aid Training is a nationally respected evidenced based practice "skills-based training course that teaches participants to identify, understand and respond to mental health and substance use challenges." The MHSA update on the community mental health needs assessment emphasized a need for prevention and early intervention serves, as well as outreach and awareness - not stigmatizing conversations and terminology, building trust to address barriers. There was also an identified need for youth specific training and inclusivity a This EBP focuses on education to reduce stigma and includes education across generations and throughout the community. Training is specialized for Youth and Adults and, in 2023-2024, 2 VCBH trainers were trained in providing the training in Spanish.

Seeking Safety directly impacts the need to address CHMNA identified needs related to substance use co-occurring with mental health issues, in particular trauma. Treatment Innovations describes it as follows: "Seeking Safety is an evidence-based, present-focused counseling model to help people attain safety from trauma and/or addiction. The Seeking Safety book describes how to conduct it in groups of any size as well as individual modality, for all genders. The model has been used with adults and adolescents (and some elements can be used with younger ages). In over 30 years of use, it has been found to be extremely safe. At every session, both trauma and addiction are addressed but without delving into the past (the detailed narrative of disturbing trauma and addiction memories). It can thus be implemented with any client, from the start of treatment, at all levels of care and the full range of treatment settings. So too any facilitator can conduct it, including all types of professionals as well as peers, paraprofessionals, and advocates."

Addressing the CHMNA identified need to expand types of treatment, VCBH offered training in the Community Resiliency Model as an alternate trauma informed treatment. "The Community Resiliency Model (CRM)® is evidence-based and trains community members to not only help themselves but to help others within their wider social network. The primary focus of this skills-based, stabilization program is to re-set the natural balance of the nervous system. CRM's goal is to help to create "trauma-informed" and "resiliency-focused" communities that share a common understanding of the impact of trauma and chronic stress on the nervous system and how resiliency can be restored or increased using this skills-based approach."

Further, MHFA, Seeking Safety and Community Resiliency Model may be utilized by any facilitator, including all types of licensed certified and unlicensed professionals (including ADTS counselors) as well as peers, paraprofessionals (MHAs, CSCs), and advocates, expanding meeting the identified need to develop more non-clinical provider options and the breadth of who may be helped by these practices, especially given the survey results indicating that almost 1 of 5 respondents reporting having suicidal thoughts and suicide attempts and the prevalence of trauma, depression and anxiety identified by the focus groups.

VCBH was able to support additional diversity and equity training, addressing underserved groups and Outreach and Education strategies, including SOGIE training, additional co-occurring disorder treatment training, diagnosis training and suicide prevention training (see additional sheet for complete 23-24 list). All topics identified on the CHMNA.

Include examples of notable community impact.

MHSA

- Number of facilitators = 6
- Number of MHFA training for VCBH staff = 3
- Number MHFA training for county/community = 3
- Total trained: 63; VCBH = 32; non VCBH = 31

Seeking Safety

In FY23-24, 56 VCBH staff attended Seeking safety Training

CRM

In FY23-24, 45 VCBH Staff and 8 CBO staff attended CRM training, and 23 and 21 CBO staff attended CRM Training with Spanish Interpretation.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Workforce Education and Training (WET)

Training Programs

Training Name	Date	Total Attendees	Non-VCBH Attendees	VCBH Attendees	Topic of Training	Topics-Secondary	Job Classif.
Seeking Safety Clinical Consultation Sessions July 2023	07/01/2023	15	11	4	Clinical		
Seeking Safety - Introductory Session	07/14/2023			0	Clinical		
Seeking Safety Clinical Consultation Sessions August 2023	08/01/2023	16	14	2	Clinical		
Seeking Safety Clinical Consultation Sessions September 2023	09/01/2023	4		4	Clinical		Clinical
Advanced Seeking Safety	09/13/2023			0	Clinical		
DSM 5TR Update: What Every Clinician Needs to Know	09/19/2023	242	200	42	Clinical		
DSM 5TR Update: What Every Clinician Needs to Know	09/21/2023	228	180	48	Clinical		
Clinical Supervision: Intro 15 hour	09/26/2023			0	Clinical		Clinical
DSM 5TR Update: What Every Clinician Needs to Know	09/28/2023	204	167	37	Clinical		
Seeking Safety Clinical Consultation Sessions October 2023	10/01/2023	6		6	Clinical		Clinical
DSM 5TR Update: What Every Clinician Needs to Know	10/05/2023	65	57	8	Clinical		
Suicide Prevention & Intervention	10/06/2023	54	35	19	Clinical	Trauma	Clinical
DSM 5TR Update: What Every Clinician Needs to Know	10/10/2023	93	89	4	Clinical		
Seeking Safety - Introductory Session	10/13/2023	28		28	Clinical		

COMMUNITY SERVICES AND SUPPORTS (CSS)

Workforce Education and Training (WET)

Training Programs

Training Name	Date	Total Attendees	Non-VCBH Attendees	VCBH Attendees	Topic of Training	Topics-Secondary	Job Classif.
Seeking Safety Clinical Consultation Sessions November 2023	11/01/2023			0	Clinical		
Special Topics in Suicide: LGBTQ+, Older Adults, Support for Survivors of Suicide Loss	11/17/2023	79	63	16	Cultural Comp		Clinical
Seeking Safety Clinical Consultation Sessions December 2023	12/01/2023			0	Clinical		
Seeking Safety Clinical Consultation Sessions, January	01/01/2024	9	9	0	Clinical		Clinical
Seeking Safety - Introductory Session	01/26/2024	157	136	21	Clinical		
Seeking Safety Clinical Consultation Sessions, February	02/01/2024	20	16	4	Clinical		Clinical
Suicide Prevention & Intervention	02/15/2024	77	77	0	Clinical	Trauma	Clinical
Advanced Seeking Safety	02/28/2024	82	61	21	Clinical		
Seeking Safety Clinical Consultation Sessions, March	03/01/2024	18	11	7	Clinical		Clinical
Seeking Safety - Introductory Session	03/22/2024			0	Clinical		
Seeking Safety Clinical Consultation Sessions, April	04/01/2024	23	18	5	Clinical		Clinical
SCRP Clinical Supervision - 15 hour	04/02/2024	67	59	8	Clinical		Clinical
SCRP - Suicide Prevention & Intervention	04/17/2024			0	Clinical		Clinical
Advanced Seeking Safety	04/24/2024	67	60	7	Clinical		

COMMUNITY SERVICES AND SUPPORTS (CSS)

Workforce Education and Training (WET)

Training Programs

Training Name	Date	Total Attendees	Non-VCBH Attendees	VCBH Attendees	Topic of Training	Topics-Secondary	Job Classif.
Seeking Safety Clinical Consultation Sessions, May	05/01/2024	24	17	7	Clinical		Clinical
Seeking Safety Clinical Consultation Sessions, June 2024	06/01/2024			0	Clinical		Clinical
Seeking Safety - Introductory Session	06/18/2024	11		11	Clinical		
Introduction to DBT	06/25/2024	46	7	39	Clinical		
CBT Basics	11/15/2023	43	38	5	Clinical	Trauma, depression, anxiety and other clinical issues	Clinical
	Cognitive therapy is one of the few forms of psychotherapy that has been scientifically tested and found to be effective in over three hundred clinical trials for many different disorders. In contrast to other forms of psychotherapy, cognitive therapy is usually more focused on the present, more time-limited, and more problem-solving oriented. Indeed, much of what the patient does is solve current problems. In addition, patients learn specific skills that they can use for the rest of their lives. These skills involve identifying distorted thinking, modifying beliefs, relating to others in different ways, and changing behaviors.						

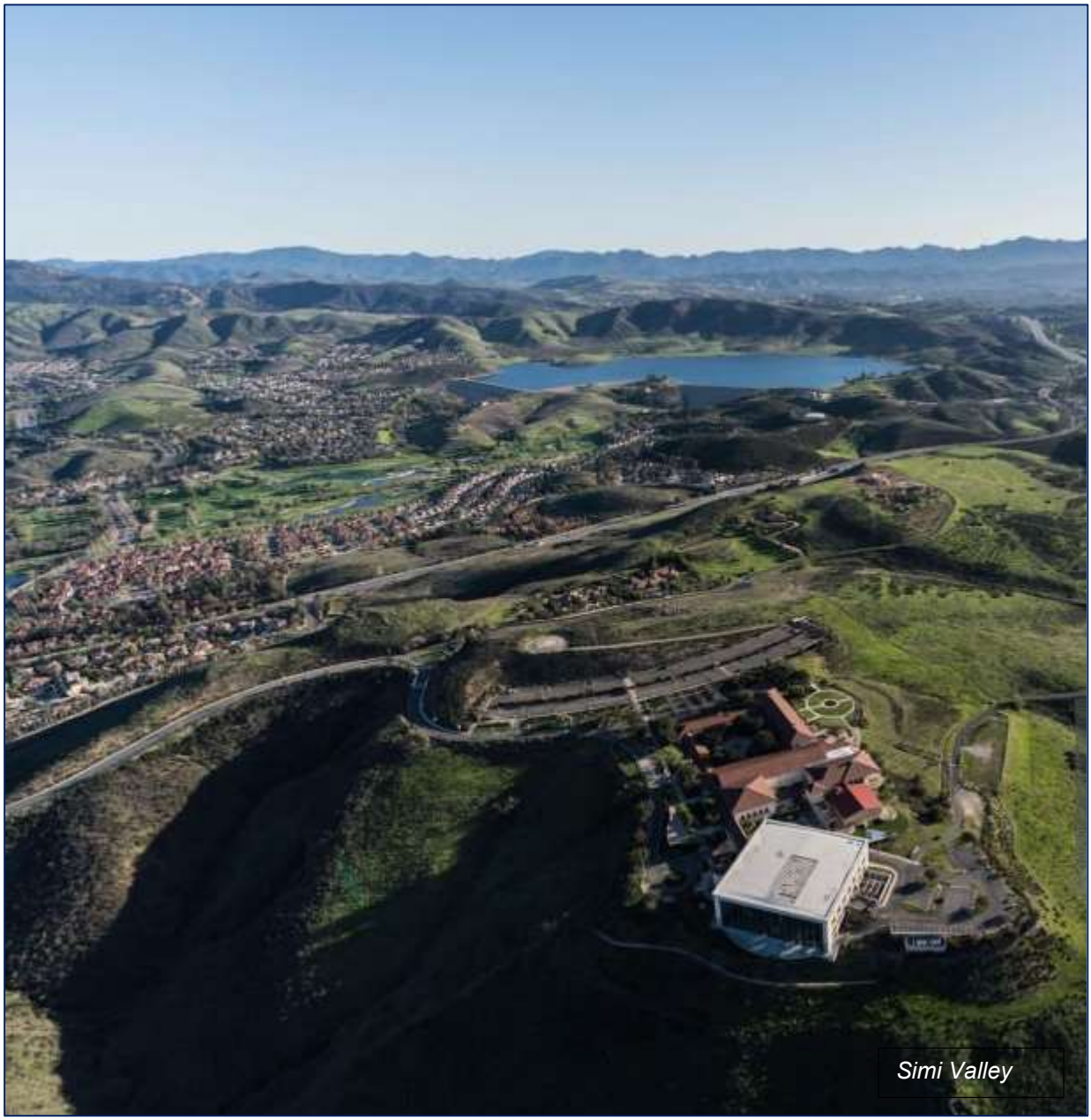
COMMUNITY SERVICES AND SUPPORTS (CSS)

Capital Facilities & Technological Needs (CTFN)

Project name: Youth and Family Resource Community Center (YFCRC)

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The current status of the Youth and Family Community Resource Center (YFCRC) is that the designers are at 50% completion of the Design Development Phase. The main challenge that was addressed this year was that the original construction budget was based several years prior to the agreement execution and the escalation rates have been high for each passing year. The design team had to redesign the project with less square footage so that the project could be built within budget. The Behavioral Health staff have coordinated with the design team to develop inviting and efficient suites for each of the programs. The essential program space has been maintained so there is no reduction in services. One concern that the Public Works team has recently expressed is that with the recent fire events in Southern California, labor and materials rates will be even higher than originally projected. In addition, during good times it is difficult to persuade quality contractors to work in Ventura County, with the upcoming massive construction efforts in LA County, it will be difficult to entice contractors to bid on our upcoming construction projects.



Simi Valley

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Fiscal Year 2024-25 Mental Health Services Act Annual Update Funding Summary

Community Services & Support (CSS)

Date: 04/04/2025

County: Ventura

	Fiscal Year 2024-2025					
	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						
Adult						
Adult Clinic-Based FSP	247,510	134,095	109,625			3,790
Assisted Outpatient Treatment (AOT) Program (Laura's Law)	1,116,506	720,621	378,762			17,123
Care Act Program	679,686	64,563	67,968			547,155
VCBH FSP Treatment Program	401,578	401,578				
Empowering Partners through Integrative Community Services (EPICS)	1,124,764	553,379	557,515			13,869
VISTA	775,964	100,504	625,332			50,127
TAY						
Transitional Age Youth (TAY) Outpatient Treatment Program	195,960	92,678	95,090			8,193
Empowering Partners through Integrative Community Services (EPICS)	10,316	5,075	5,113			127
Assisted Outpatient Treatment (AOT) Program (Laura's Law)	375,894	242,611	127,518			5,765
VISTA	50,698	6,566	40,856			3,275
Casa Esperanza TAY Transitions Program (TAY FSP)	1,131,722		1,058,387			73,336
Youth and Family (Y&F) FSP	354,986	35,499	319,488			
Adult Clinic-Based FSP	11,545	6,255	5,114			177
Youth						
Youth and Family (Y&F) FSP	469,141	42,066	422,227			4,848
Older Adults						
VCBH Older Adults FSP Program	2,393,764	1,437,577	948,421			7,766
Adult Clinic-Based FSP	55,259	29,938	24,475			846
Empowering Partners through Integrative Community Services (EPICS)	477,594	234,974	236,730			5,889
VISTA	136,491	17,678	109,995			8,817
Assisted Outpatient Treatment (AOT) Program (Laura's Law)	67,051	43,277	22,746			1,028

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Fiscal Year 2024-25 Mental Health Services Act Annual Update Funding Summary

Community Services & Support (CSS)

County: Ventura

Date: 04/04/2025

	Fiscal Year 2024-2025					
	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
Non-FSP Programs						
Crisis Stabilization Unit (Children)	3,946,013	3,487,881	394,601			63,531
Mobile Response Team (MRT)	1,200,894	1,080,804	120,089			
ARPA - Peer Support Program	758,845	526,380				232,465
The Client Network (CN)	283,236	283,236				
County-Wide Crisis Team (CT)	4,248,527	3,204,213	1,006,522			37,791
Youth & Family Intake Team	1,173,660	1,101,743	70,327			1,590
Adult Short Term Treatment Program	2,396,341	1,900,208	463,534			32,598
Rapid Integrated Support and Engagement (RISE)	2,354,011	1,629,498	478,990			245,523
Crisis Residential Treatment (CRT)	4,444,471	1,100,752	3,111,130			232,589
MCOT TAY	538,919	309,643	128,240			101,037
Fillmore Community Project	763,417	67,742	687,075			8,600
Family Access Support Team (FAST)	971,341	708,334	97,134			165,873
VCBH Adult Outpatient Treatment Program	27,993,354	8,943,685	16,226,316			2,823,353
Transitional Age Youth (TAY) Outpatient Treatment Program	2,716,541	1,284,767	1,318,203			113,571
Housing	6,134,963	1,931,914				4,203,049
TAY Wellness Center	700,253	700,253				
Growing Works	455,514	140,471	304,683			10,361
Wellness and Recovery Center and Mobile Wellness	1,386,201	1,386,201				
Wellness Everyday	392,697	392,697				
Providers' Infrastructure upgrades and modifications	828,692	828,692				
East County Crisis Stabilization Unit (CSU)	250,000	250,000				
Crisis Tracking System	189,482	189,482				

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Fiscal Year 2024-25 Mental Health Services Act Annual Update Funding Summary

Community Services & Support (CSS)

County: Ventura

Date: 04/04/2025

	Fiscal Year 2024-2025					
	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
Non-FSP Programs						
Transcranial magnetic stimulation (TMS)	312,814	312,814				
Y&F Community Resource Center	256,274	256,274				
Y&F Enhanced Care Management (ECM)	129,574	129,574				
Upgrades, remodeling, expansion of current service sites	478,265	478,265				
VCBH Access Program	2,137,747	1,795,398	320,662			21,687
Moorpark EPSDT & O&E Services	92,087	92,087				
New Vehicles for CSS	200,000	200,000				
DSH Diversion Grant	583,500					583,500
CSS Administration	9,029,448	4,827,513	2,922,134			1,279,801
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	87,423,509	43,709,454	32,805,003			10,909,053
FSP Programs as Percent of Total	23.1%					

County: Ventura Date: 3/17/2025

	Fiscal Year 2025-2026					
	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						
Adult						
Adult Clinic-Based FSP	694,411	418,779	257,926			17,707
Assisted Outpatient Treatment (AOT) Program (Laura's Law)	366,835	10,783	322,150			33,903
VCBH FSP Treatment Program	85,897	85,897				
Care Act Program	626,435	437,755	79,799			108,880
Empowering Partners through Integrative Community Services (EPICS)	1,326,827	711,640	605,229			9,957
VISTA	1,020,739	37,426	923,414			59,899
TAY						
Transitional Age Youth (TAY) Outpatient Treatment Program	212,325	122,866	83,747			5,713
Empowering Partners through Integrative Community Services (EPICS)	12,169	6,527	5,551			91
Assisted Outpatient Treatment (AOT) Program (Laura's Law)	376,370	256,498	108,458			11,414
VISTA	66,690	2,445	60,331			3,914
Casa Esperanza TAY Transitions Program (TAY FSP)	1,034,119	9,975	974,136			50,008
Adult Clinic-Based FSP	32,392	19,535	12,031			826
Youth and Family (Y&F) FSP	982,022	800,008	163,004			19,010
Child						

Child Welfare

Fiscal Year 2024-25 Mental Health Services Act Annual Update Funding Summary

Community Services & Support (CSS)

Youth and Family (Y&F) FSP	860,127	700,705	142,771			16,650
Assisted Outpatient Treatment (AOT) Program (Laura's Law)	1,460	1,207	233			20

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Fiscal Year 2024-25 Mental Health Services Act Annual Update Funding Summary

Community Services & Support (CSS)

County: Ventura Date: 04/04/2025

	Fiscal Year 2025-2026					
	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						
Older Adults						
VCBH Older Adults FSP Program	2,139,816	1,628,445	509,282			2,088
Empowering Partners through Integrative Community Services (EPICS)	563,393	302,174	256,991			4,228
VISTA	179,546	6,583	162,427			10,536
Adult Clinic-Based FSP	155,034	93,496	57,584			3,953
Assisted Outpatient Treatment (AOT) Program (Laura's Law)	67,136	45,754	19,347			2,036

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Fiscal Year 2024-25 Mental Health Services Act Annual Update Funding Summary

Community Services & Support (CSS)

County: Ventura Date: 04/04/2025

	Fiscal Year 2025-2026					
	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
Non-FSP Programs						
Crisis Stabilization Unit (Children)	4,867,932	4,449,583	408,271			10,078
Crisis Tracking System	18,000	18,000				
ARPA - Peer Support Program	120,418	120,418				
The Client Network (CN)	292,816	292,816				
County-Wide Crisis Team (CT)	4,556,025	3,735,012	687,705			133,308
Youth & Family Intake Team	804,202	185,140	539,742			79,320
Rapid Integrated Support and Engagement (RISE)	2,250,360	1,675,071	166,610			408,678
Crisis Residential Treatment (CRT)	7,226,650	3,998,170	3,073,494			154,986
MCOT TAY	446,840	369,144	68,616			9,079
Fillmore Community Project	824,650	270,337	534,452			19,861
Family Access Support Team (FAST)	1,414,154	1,099,940	143,221			170,993
Mobile Response Team (MRT)	1,027,225	844,922	137,714			44,589
VCBH Adult Outpatient Treatment Program	30,169,507	10,152,561	16,794,054			3,222,892
Adult Short Term Treatment Program	3,100,376	569,616	2,358,317			172,443
Access Program (Access Line)	2,267,774	2,115,883	138,690			13,201
Transitional Age Youth (TAY) Outpatient Treatment Program	2,915,018	1,674,862	1,160,962			79,193
Crisis Stabilization Unit (Children)	4,867,932	4,449,583	408,271			10,078
Crisis Tracking System	18,000	18,000				
ARPA - Peer Support Program	120,418	120,418				
The Client Network (CN)	292,816	292,816				
County-Wide Crisis Team (CT)	4,556,025	3,735,012	687,705			133,308
Upgrades, remodeling, expansion of current service sites	190,504	190,504				
Housing	9,047,650	3,775,178				5,272,472
TAY Wellness Center	653,152	652,058				1,093
Growing Works	668,206	474,731	190,927			2,549
Wellness Everyday	234,002	234,002				

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Fiscal Year 2024-25 Mental Health Services Act Annual Update Funding Summary

Community Services & Support (CSS)

County: Ventura Date: 04/04/2025

	Fiscal Year 2025-2026					
	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
Non-FSP Programs						
Wellness and Recovery Center and Mobile Wellness	1,410,547	1,410,547				
Moorpark EPSDT & O&E Services	1,487,878	905,909	581,970			
Child Welfare Subsystem Program	427,394	345,669	79,375			2,350
East County CSU	3,225,863	3,225,863				
Nate's Place Wellness and Recovery Center	84,000	84,000				
Candela Group	92,400	92,400				
Creativity through Music	509,500	509,500				
Semillas Counseling and Wellness	285,765	285,765				
Employment Services for SMI	500,000	500,000				
Therapy Dogs	250,000	250,000				
One-Stop Site Parent Center	456,616	456,616				
Electroconvulsive therapy (ECT)	75,000	75,000				
Mesa Independent Living	31,500	31,500				
New Vehicles for CSS	800,000	800,000				
Locked MHRC Unit (Lewis Rd) Operations	2,500,000	2,500,000				
Transcranial magnetic stimulation (TMS)	362,277	362,277				
DSH Diversion Grant	1,797,863	558,163	407,500			832,200
CSS Administration	14,259,562	8,274,037	2,589,609			3,395,917
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	116,300,454	66,373,509	35,519,777			14,407,168
FSP Programs as Percent of Total	22.1%					

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Fiscal Year 2024-25 Mental Health Services Act Annual Update Funding Summary

Prevention and Early Intervention (PEI)

County: Ventura Date: 04/04/2025

	Fiscal Year 2024-2025					
	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
Outreach, Referral & Engagement (OR&E) Programs						
One Step a la Vez PEI	403,745	403,745				
Project Esperanza	138,600	138,600				
Tri County Glad	93,740	93,740				
Catalyst Church	256,589	256,589				
Logrando Bienestar	1,789,066	948,975	822,027			18,065
Suicide Prevention Efforts and Events	719,705	719,705				
Crisis Intervention Team (CIT) Training	292,106	292,106				
Network Expansion Grants (Formerly Mini Grant) Pilots	895,166	895,166				
Primary Care Program						
Primary Care Program	436,991	436,991				
Promotoras Programs						
Healing the Community - (MICOP)	345,562	345,562				
K-12						
K-12 Prevention	2,349,250	2,349,250				
Wellness Centers Expansion K-12	2,318,944	2,313,062				5,882
PEI Programs - Early Intervention						
One Step a la Vez EIP	124,704	124,704				
Ventura County Power Over Primordial Psychosis (VCPOPs)	1,745,311	713,225	690,130			341,956
Older Adults - VCAAA	730,266	730,266				
COMPASS	2,291,203	1,728,218	385,687			177,298
VC Family Justice Peer	517,850	517,850				
Eye movement desensitization and reprocessing (EMDR)	271,803	271,803				
Prevention						
MHSSA Grant-Wellness Centers K-12	1,380,685	92,123				1,288,562
Wellness Centers at Community Colleges	543,279	543,279				
Stigma & Discrimination Reduction						
Diversity Collective	82,654	82,654				
CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY	92,082	92,082				
EVALCORP	426,149	426,149				
PEI Administration	2,510,969	1,390,823	821,658			298,488

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Fiscal Year 2024-25 Mental Health Services Act Annual Update Funding Summary

Prevention and Early Intervention (PEI)

County: Ventura Date: 04/04/2025

	Fiscal Year 2025-2026					
	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
Outreach, Referral & Engagement (OR&E) Programs						
One Step a la Vez PEI	375,205	375,205				
Project Esperanza	128,803	128,803				
Tri County Glad	87,114	87,114				
Catalyst Church	208,228	208,228				
Logrando Bienestar	1,921,044	1,119,440	767,674			33,930
Suicide Prevention Efforts and Events	513,638	513,638				
Crisis Intervention Team (CIT) Training	250,960	250,960				
Primary Care Program						
Primary Care Program	911,271	423,044				488,226
Promotoras Programs						
Healing the Community - (MICOP)	289,994	289,994				
K-12						
K-12 Prevention	2,079,225	2,079,225				
Wellness Centers Expansion K-12	1,985,434	1,985,434				
PEI Programs – Early Intervention						
One Step a la Vez PEI	133,814	133,814				
Ventura County Power Over Primordial Psychosis (VCPOPs)	3,111,028	1,303,749	1,352,861			454,418
Older Adults - VCAAA	627,399	627,399				
COMPASS	2,263,592	1,768,608	370,462			124,522
VC Family Justice Center	63,000	63,000				
VC Family Justice Peer	796,471	796,471				
Eye movement desensitization and reprocessing (EMDR)	232,623	232,623				
Wellness Centers at Community Colleges	625,327	625,327				
Prevention						
Amplify Arts Project (Girls Rock SB)	73,452	73,452				
Autism Society of Ventura County	33,810	33,810				
Boys and Girls Club of Greater Oxnard & Port Hueneme	31,500	31,500				

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Fiscal Year 2024-25 Mental Health Services Act Annual Update Funding Summary

Prevention and Early Intervention (PEI)

County: Ventura Date: 04/04/2025

	Fiscal Year 2025-2026					
	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
Prevention						
De Colores Multicultural Folk Arts. Inc.	52,159	52,159				
Namba Performing Arts	38,236	38,236				
No Limits Theater Group, Inc.	71,439	71,439				
Nyeland Promise	28,403	28,403				
Two Trees Community	88,415	88,415				
MHSSA Grant-Wellness Centers K-12	1,178,097	255,346				922,752
Teen Drop-In Center	350,000	350,000				
Mental Health Community Events	35,000	35,000				
Mental Health Services for PEI	250,000	250,000				
Girl Scout Badge Program - Mental Health Awareness	84,000	84,000				
Stigma & Discrimination Reduction						
Oxnard Performing Arts Center Corporation	89,250	89,250				
Diversity Collective	76,811	76,811				
Mental Health First Aid - In Spanish	50,000	50,000				
Mental Health Awareness through Arts	750,000	750,000				
CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY	41,157	41,157				
EVALCORP	377,167	377,167				
PEI Administration	3,347,817	2,015,316	649,686			682,815
Total PEI Program Estimated Expenditures	23,696,562	17,849,215	3,140,683			2,706,663

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Fiscal Year 2024-25 Mental Health Services Act Annual Update Funding Summary

Innovation (INN)

Date: 04/04/2025

	Fiscal Year 2024-2025					
	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						
CAREGIVERS Homeless Prevention-M.A.S.H Senior for Homeless Prevention						
CAREGIVERS Homeless Prevention-M.A.S.H Senior for Homeless Prevention-ADMIN	159,211	159,211				
CAREGIVERS Homeless Prevention-M.A.S.H Senior for Homeless Prevention-EVALUATION						
Learning Healthcare Network (LCHN)						
Learning Healthcare Network (LCHN) - ADMIN	466,000	466,000				
Learning Healthcare Network (LCHN)- EVALUATION	53,985	47,272	6,713			
Therapeutic Crisis Response-Mobile Mental Health Van						
Therapeutic Crisis Response-Mobile Mental Health Van-ADMIN	445,619	445,619				
Therapeutic Crisis Response-Mobile Mental Health Van-EVALUATION	335,838	294,079	41,759			
INN Administration						
Total INN Program Estimated Expenditures	289,867	154,558	94,097			41,211

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Fiscal Year 2024-25 Mental Health Services Act Annual Update Funding Summary

Innovation (INN)

Date: 04/04/2025

	Fiscal Year 2025-2026					
	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						
CAREGIVERS Homeless Prevention-M.A.S.H Senior for Homeless Prevention						
CAREGIVERS Homeless Prevention-M.A.S.H Senior for Homeless Prevention-ADMIN	216,808	216,808				
CAREGIVERS Homeless Prevention-M.A.S.H Senior for Homeless Prevention-EVALUATION	18,210	18,210				
CMH Training Program						
CMH Training Program - ADMIN	396,384	396,384				
CMH Training Program - EVALUATION	33,293	33,293				
Learning Healthcare Network (LCHN)						
Learning Healthcare Network (LCHN) - ADMIN	1,675,825	1,675,825				
Learning Healthcare Network (LCHN)- EVALUATION	129,272	129,272				
Therapeutic Crisis Response-Mobile Mental Health Van						
Therapeutic Crisis Response-Mobile Mental Health Van-ADMIN	537,344	537,344				
Therapeutic Crisis Response-Mobile Mental Health Van-EVALUATION	45,133	45,133				
Veteran Mentorship Program						
Veteran Mentorship Program - ADMIN	819,387	819,387				
Veteran Mentorship Program - EVALUATION	68,822	68,822				

Fiscal Year 2024-25 Mental Health Services Act Annual Update Funding Summary

Workforce Education and Training (WET)

Date: 04/04/2025

	Fiscal Year 2024-2025					
	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						
Workforce Education & Training Stipends	45,773	45,773				
MIP Integrated Care & Outreach Site	92,850					92,850
MIP MH Outpatient Specialty Care	98,537					98,537
Continued Staff Training	74,660	74,660				
WET Administration	34,871	34,871				
Total WET Program Estimated Expenditures	346,690	155,304				191,387

	Fiscal Year 2025-2026					
	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						
Workforce Education & Training Stipends	247,043	247,043				
Mental Health First Aid Training	26,768	26,768				
Continued Staff training	100,000	100,000				
WET Administration	52,665	52,665				
Total WET Program Estimated Expenditures	426,477	426,477				

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Fiscal Year 2024-25 Mental Health Services Act Annual Update Funding Summary

Capital Facilities/Technological Needs (CFTN)

Date: 04/04/2025

	Fiscal Year 2024-2025					
	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						
Youth & Family Community Resource Center	1,464,294					1,464,294
PHF Psychiatric Health Facility	970,074	970,074				
Locked MHRC Unit (Lewis Rd)	2,000,000	2,000,000				
CFTN Administration	551,806	551,806				
Total CFTN Program Estimated Expenditures	4,986,174	3,521,880				1,464,294

	Fiscal Year 2025-2026					
	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						
Youth & Family Community Resource Center	651,412					651,412
Adult Crisis Stabilization Unit - Simi Valley	1,500,000	1,500,000				
Locked MHRC Unit (Lewis Rd)	3,000,000	3,000,000				
PHF Psychiatric Health Facility	500,000	500,000				
Board & Care Facility Acquisition	6,500,000	6,500,000				
Financial System Update	600,000	600,000				
CFTN Administration	443,992	443,992				
Total CFTN Program Estimated Expenditures	13,195,404	12,543,992				651,412

Public Comments

30 Day Review

The opening of the 30-day public review began April ____th, 2025 and was announced at the Behavioral Health Advisory Board meeting. The public review window closed on May ___th, 2025.

Public Hearing

(Content)

Social Media

(Content)

Changes to the MHSA 23-24 Annual Update report since April 15th, 2023

Changes are listed below:

Several of the projects outlined in the 3-year plan were proposed before budgets could be accurately represented. Now that the Department has had time to research some of these costs and get bids for the following initiatives the anticipated cost will be higher than originally estimated. In part the additional increases in these projects are in place to address the need to reallocate estimates from additional hiring and vehicle purchase items noted in the three-year plan, both of which are currently on hold due to statewide concerns of revenue shortfalls across the state and several changing laws including electric vehicle requirements, Prop 1, and BH Connect. Considering the changing landscape and unknown impact of some of these new requirements the Department is expanding on some of the umbrella projects. There are MHSA funds to cover these increased costs.

Examples of the proposed projects are outlined below and may include others like expansions. Below are the projects that have changed and were not noted in the February CPP Process or the draft Annual Update.

Administrative Infrastructure

Increased by $1,500,000, this initiative will include several projects that have been hindered by a lack of funding in previous years. With the available one-time money, projects such as rewiring of the administration building for more reliable Wi-Fi connections to support interoperability, meeting room upgrades to improve the capacity for hybrid meetings, clinic upgrades and refresh (painting, furniture, and supply replacement) and other administrative structural improvements.

Access and Outreach Education

During the most recent County health needs assessment the following priorities were set.

1. to educate around moderate-severe (VCBH domain) services versus mild-moderate (others) mental illness; and significant functional impairment (i.e., what VCBH can be expected to do).

2. Education around stigma reduction, substance use and impacts, trauma, diversity, equity, and inclusion, changes across the lifespan, and other pertinent topics. The Department will be revamping its outreach materials and public facing information to meet this need.

Housing

Cost is estimated to increase by $1,000,000. Housing continues to be a priority for the department and for the upcoming implementation of Prop 1. Housing can be funded out of all the current MHSA categories. The department is ready to expand rental subsidies, housing vouchers, and temporary housing across the County for individuals living with mental illnesses.

Alternatives to VCBH

$4,000,000 Another priority from the last County health needs assessment is to develop more contracted clinical providers/options for those in the mild-moderate category including, early intervention for underserved populations, and moderate to severe contracted services.

Workforce Enhancement and Training

Increased to $500,000 training initiatives will expand to include a greater number of training courses for the department in anticipation of upcoming legislation. Some examples are WRAP training for all peers, crisis care training, Power BI, and ACT.

PEI: Mental Health Awareness though the Arts

Increased to $750,000 In working with the CEO's office it was determined that increasing the amount would maximize the opportunity to fund multiple arts initiatives.

Changes to MHSA 23-24 Annual Update report since April 15th, 2023

Community Innovation Plans: The program item in the 3-year plan named Community Innovation Plans outlined is a place holder for a planned community engagement where the public would be able to put forward ideas for an innovation program. A Community Program Planning Process (CPPP) exclusive to Innovation ideas was planned to take place in FY23/24 and is now complete. A public call for submissions took place in January inviting anyone with an innovative approach to mental health to apply for a grant. A total of 38 submissions were received. A work group was assembled with eighteen participants across the county who reviewed all submissions. Each participant voted for their top three choices. The department will be pursuing the following Innovation ideas in the next year.

Budgets are not yet final for the current INN proposals already listed in the 3-year plan. However, a CPPP is a timely process that requires a wide range of participants to meet the state requirements so the department opted to continue with the process in hopes that the process can continue to move forward.

Next steps in the process would include a 30-day public posting of a full proposal, Board of Supervisors approval and State approval via the Mental Health Services Oversight and Accountability Commissions (MHSOAC) protocols. As this is a lengthy process, the department is also notifying the community that it may need to pivot to another MHSA funding component such as PEI or CSS to ensure one or more of the submitted INN proposals can still take place with the one-time funding bump should INN funding be unavailable.

In particular, the Department continues to seek ways to reach underserved communities in the County considering that ongoing effort and the robust INN submission process. The Department would like to add a new initiative to the plan.

Prevention Programs for Underserved Populations: Allocation $500,000 This will allow the department the opportunity to fund some of the innovation submissions that were not voted on to be innovative project plans but did meet the qualifications for PEI monies.

The following are the three Innovation projects that have been selected for consideration to be pursued with the MHSOAC.

The Arts & Culture Program for Survivors of Trauma & Crime, submitted by *Creativity Through Music.*

The Culturally-rooted Horticulture-assisted Psychotherapy and Somatic Practices, submitted by *Semillas Counseling & Wellness*

The Family Justice Center Peer Program, submitted by the *Ventura County District Attorney's Office – Family Justice Center.*

Appendices

Appendix A: Ventura - 2024 _MASH Y2 Annual Report FY 23_24

Ventura County Behavioral Health

Mental Health Services Act

Innovation Project

Managing Assets for Security and Health Senior Supports for Housing Stability

Annual Report
Fiscal Year 2023-2024
Year Two

October 2024

Introduction

On March 21, 2022, the Mental Health Services Oversight and Accountability Commissions (MHSOAC) approved the use of Mental Health Services Act Innovation Component funding for Ventura County Behavioral Health (VCBH) to implement the Managing Assets for Security and Health (MASH) project. This is the second annual project report and describes activities that took place during FY 2023-2024.

This report has been developed to provide the MHSOAC and Ventura County stakeholders with a status update on this project. In accordance with Title 9 California Code of Regulations (9 CCR § 3580.010), a report is to be submitted to the MHSOAC each year that includes the following:

- Whether and what changes were made to the Innovation Project during the reporting period and the reasons for changes.
- Available evaluation data, including outcomes of the Innovation Project and information about which elements of the Project are contributing to outcomes.
- Program information collected during the reporting period, including the number of participants and demographics of participants served.
- Any other data the County considers relevant.

Project Overview

VCBH contracted with CAREGIVERS: Volunteers Assisting the Elderly in Ventura County to implement the MASH project. CAREGIVERS is a non-profit agency that recruits volunteers to support home-bound older adults. MASH was launched for low-income older adults aging in place with limited income who fear losing their housing due to fiscal, cognitive, or physical restrictions. The program began on October 1, 2022, and is scheduled to end June 30, 2027.

The Problem

Older adults at risk of or currently experiencing homelessness are becoming increasingly prevalent. Older adults with little to no savings or retirement income are on the brink of financial crisis and can quickly be destabilized by sudden changes like a rent increase, medical issues, or the death of a partner or caregiver. Since the pandemic, the housing market has worsened with rent and housing prices soaring. Additionally, fraud abuse among older adults is rampant and can negatively impact their financial situation, increasing their risk of homelessness. Anecdotally, older adult service providers have observed an increase in requests for services and the need for financial counseling from those with low incomes who did not anticipate housing expenses rising so quickly.

The Solution

The purpose of the Managing Assets for Security and Health (MASH) program is to provide multiple supports for older adults at risk of homelessness. Volunteers provide creative case management during a 90-day process that includes intake and screening, case planning, referrals and coordination, ongoing support, and case closure. Once an individual's financial situation is understood, volunteers can offer therapeutic and material support to enrolled clients through education, recommendations, referrals, and personal assistance. Older adults must also be enrolled with the CAREGIVERS organization to be eligible for the MASH program. MASH clients are not required to follow any of the guidance provided to them.

Assumptions of Program Approach. By assigning and monitoring volunteers to work with homebound older adults, the clients will build a trusting relationship with the organization and be more likely to engage in a housing resource plan that includes essential services and concrete resources as needed. MASH clients will be able to explore multiple solutions to their financial and housing situations over time, raising the chances for increased stability.

Learning Goals

The learning goals and questions to be addressed through the MASH program are:

1. Does enrollment in the MASH program have an impact on the client's motivation to change their housing situation?
2. How much does the program improve clients' sense of security and safety?
   - Aim 1: Living situation
   - Aim 2: Fiscal situation
3. Does enrollment in the program reduce feelings of depression, anxiety, and isolation?
4. Does the program have an effect on enrolled clients' housing situation as measured by the following three aims:
   - Aim 1: Prolonged ability to stay in current housing
   - Aim 2: Reduced evictions
   - Aim 3: Stably housed 6-12 months post-discharge

Project Updates in FY 2023-2024

During this fiscal year, the MASH project implemented significant changes in its program staff, processes, and budgeting (described below) to develop a replicable model for addressing financial and housing insecurity among older adults. CAREGIVERS collaborated with the National Volunteer Caregiving Network (NVCN) to establish a California learning community for volunteer caregiving organizations, fostering a collaborative network that lays the groundwork for expanding the MASH program statewide. Additionally, the project will be showcased at the 40th Anniversary Conference of the NVCN in November 2024 to introduce the program to organizations across the country.

New Volunteer Coordinator

The original MASH volunteer coordinator left the position in quarter three of the fiscal year. In quarter four, a new program coordinator was hired who brought a fresh perspective to MASH. She helped refine existing procedures including streamlining monthly program meetings and developing a task-tracking system for MASH volunteers. Her efforts have led to more focused and efficient meetings with MASH volunteers.

Client Engagement

The MASH team learned the importance of building rapport with clients before diving more deeply into their financial situation in quarter two, leading to changes in how they engaged with newly enrolled clients. Originally, clients were immediately presented with a checklist outlining the financial documents they needed to share after they had agreed to participate in the MASH program during their first visit. This was believed to be the most efficient process as it allowed the team to quickly begin to better understand the client's financial situation. However, after several clients were reluctant to share information and canceled their future appointments, the MASH team determined this approach to the

first meeting was overwhelming and intimidating. The revised engagement strategy now includes having a casual conversation with clients during the first meeting to build rapport and trust between them and volunteers, which has increased clients' openness to working with the MASH team.

Redesigned Budget

In quarter four of the fiscal year, MASH leadership decided to apply a more flexible approach to spending their 'Housing Gap Assistance' funds. These funds were originally designated for the following:

- *Immediate support* resources to ensure the individual does not become homeless. (e.g., financial assistance, temporary shelter, rapid rehousing, etc.)
- *Age in place supports* (e.g., include family network to move in if practical, handicap accessible or other home modifications, home share, reverse mortgages, utilities, or other bills requiring backpay, etc.)
- *Moving Supports* (e.g., secure placement in new housing arrangement, first/last month securities, downsizing, light rental subsidy, etc.)

However, only being able to provide such specialized support for housing changes has limited the program's ability to meaningfully address clients' needs. For example, one of the greatest threats to clients' housing stability and security has been unexpected major expenses such as plumbing issues or the need for a roof repair. With greater discretion regarding how funds can be used in the upcoming fiscal year, the MASH program will have more latitude in assisting clients in problem-solving financial challenges.

Volunteer Recruitment and Retention

Volunteer participation was challenging this fiscal year. Several MASH volunteers chose to take a hiatus or resign from the program due to frustrations from not being able to help clients who were reluctant to share necessary information or meet with them. Volunteer involvement is key to the success of the MASH program as clients cannot be adequately served if volunteers are unavailable to take on cases.

To increase recruitment and retention of MASH volunteers, a flyer was developed in quarter two to better introduce the program to prospective volunteers. Program leadership also began developing a training manual to offer volunteers a more uniform and efficient onboarding process. The manual provides an overview of MASH, programming processes, volunteer responsibilities and expectations, client resources, and case studies showcasing a variety of client scenarios that may be encountered. Additionally, training for volunteers about benefits programs such as Medicare/MediCAL were scheduled to increase their knowledge of resources and comfortability advising MASH clients.

Evaluation Overview

CAREGIVERS work with the evaluation team, EVALCORP (EVC), by being responsible for collecting and submitting MASH program data. EVC conducts the analysis, completes reporting, and provides technical assistance to CAREGIVERS in their data collection efforts.

The mixed-methods evaluation includes data collected using surveys, focus groups, and interviews. No focus groups were conducted during year two. This design provides a comprehensive look at the MASH program's impacts.

Evaluation Questions

The evaluation questions closely align with the project learning goals:

1) Does enrollment in the MASH program impact the client's motivation to change their housing situation, and if yes, to what degree?
2) Does the program improve a client's sense of security and safety and if yes, to what degree?
3) Does enrollment in the program reduce feelings of depression, anxiety, and isolation and if yes, to what degree?
4) Does the program affect the enrolled client's housing situation, and if yes, how?

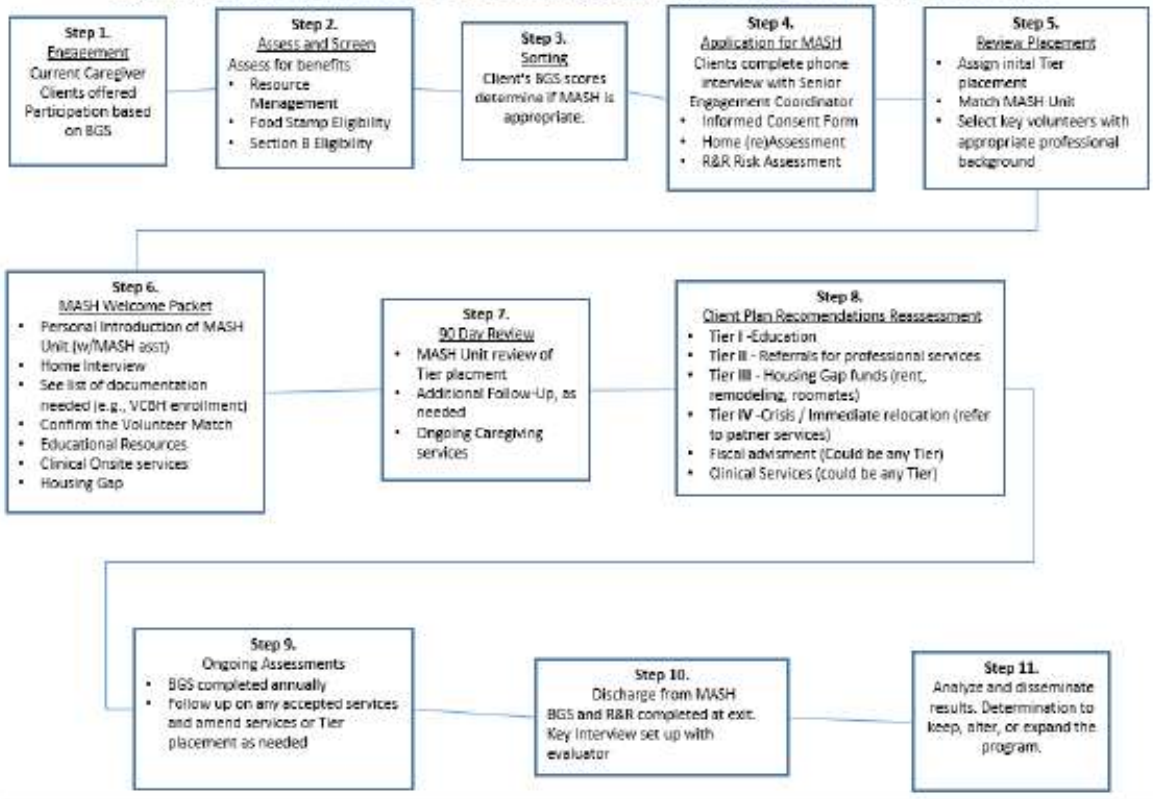
Methods

The evaluation of MASH for FY 2023-2024 is informed by five data sources: (1) BetterAge Guidance System (BGS), (2) Risk & Referral Tool (R&R), (3) program activities log, (4) client interviews and (5) quarterly reports. Demographic data was collected upon completion of the BGS survey and included in the data log. An identification number is used for all assessments. The evaluation team does not have access to the name or other identifying information related to the identification number, which is assigned by CAREGIVERS staff.

Data Collection Tools

Data collection is integrated into CAREGIVERS's process for caring for clients. Figure 1 illustrates this process, including the data collection and decision points.

Figure 1. CAREGIVERS Process for Working with Clients and Data Collection Points



The data collection tools, administration method and timing, and their descriptions are in Table 1. Data collection begins with the initial BGS survey. MASH assessment is based on one self-determined financial question in the BGS: "Please indicate where you are on the ladder right now (0 being the worst possible financial situation and 10 being the best possible financial situation)." A client is eligible to complete the next step in the MASH assessment process, the initial R&R survey, if they score below a five. Tiers are then assigned (see below) following the R&R assessment informing the MASH services they receive.

- **Tier 1** (score 0-6): Thriving, self-resolve, education
- **Tier 2** (score 7-15): Surviving, financial management
- **Tier 3** (score 16-20): Struggling, housing gap, clinical services referral
- **Tier 4**: (score 21-27): Crisis, external intervention services

Finally, the MASH team provides recommendations to enrolled MASH clients after an in-depth examination of their financial situation over the course of approximately 90 days. After that, clients are invited to complete exit BGS and R&R surveys and an interview. The tools are included in Appendices B through F.

Table 1. Data Collection Tools

Tool Name	Administration Method and Timing	Description
Demographics Form	CAREGIVERS client to complete the form at the time of screening for MASH	Includes demographic questions such as gender, sex at birth, and race/ethnicity. The demographics are entered into the data log.
BetterAge Guidance System (BGS)	This tool can be self-administered or administered verbally by a CAREGIVERS staff member or volunteer. Completed at the time of enrollment in MASH, annually, and when the case is closed*	The tool includes 14 closed-ended questions about mental, physical, and financial health as well as community connectedness. Respondents are asked to rate their responses between zero and 10.
Risk and Referral Tool (R&R)	Administered by CAREGIVERS staff or volunteers upon enrollment in MASH, annually, and when the case is closed*	Includes eight closed-ended questions about finances and safety.
Data Log	Completed by CAREGIVERS staff and submitted quarterly throughout the MASH project.	This Excel spreadsheet includes information about demographics, referrals, program activities, and success stories.
Client Interview Protocol	Facilitated by EVC researcher in years two and five.	Protocol includes questions about program experience and impacts.
Quarterly Report	Completed by CAREGIVERS staff quarterly.	Includes information about program challenges and successes, significant findings, and upcoming activities.

**If the case is closed within one month of the initial BGS assessment, the BGS was not re-administered.*

Interviews

Three phone interviews, each lasting approximately 15 minutes, were conducted with MASH clients who were discharged from the program. All interviews were facilitated by an EVC researcher and took place in August 2024. The purpose was to learn about the program's benefits and ways that it can be improved through questions related to client impacts, successes, and challenges. The interview protocol is in Appendix E.

Table 2 is a crosswalk of the evaluation questions, and the data sources used to answer that question as well as the indicators.

Table 2. Evaluation Questions, Tool Used, and Indicators

Evaluation Question	Data Source	Indicators/Metrics
Does enrollment in the MASH program impact the client's motivation to change their housing situation, and if yes, to what degree?	Risk Assessment & Referral Survey Interviews	Questions about money management, ability to cover expenses, and feedback about program impacts.
Does the program improve a client's sense of security and safety and if yes, to what degree?	Risk Assessment & Referral Survey Interviews	Survey Question. 1. Considering your current health, to what degree do you worry about your safety e.g., falls, mobility? Feedback about program impacts.
Does enrollment in the program reduce feelings of depression, anxiety, and isolation and if yes, to what degree?	BetterAge Guidance System Survey Interviews	Survey Questions. 1. How would you rate your overall mental health? 2. How often do you feel lonely? 3. How would you describe your sense of belonging to your local community? 4. During the past two weeks, how often have you experienced positive emotions such as joy, affection, or hope? 5. During the past two weeks, how often have you experienced negative emotions such as sadness, worry, or despair? Feedback about program impacts.
Does the program have an effect on enrolled clients housing situation, and if yes, how?	Interviews	Feedback about program impacts.

Data Analysis

With only four individuals completing initial and exit surveys, making pre/post comparisons of clients' scores was not advisable due to the low sample size. However, insights into program impacts were still drawn from this data. Additionally, qualitative data from client interviews and CAREGIVERS quarterly reports were analyzed using thematic analysis to further explore program outcomes.

Findings

MASH Enrollment and Demographics

A total of 302 adults have been enrolled in MASH since FY 2022-2023 and completed the initial BGS survey. Most clients were White women (79%, respectively), had private insurance (77%) and resided in Ventura (31%). A full description of demographics is included in the table below.

Demographics of MASH Clients	
Race*	**n = 297**
American Indian/Alaska Native	<1%
Asian	3%
Black/African American	3%
Hispanic/Latine	11%
Native Hawaiian, other Pacific Islander	2%
White	79%
More Than One Race	<1%
Another Race	-
Hispanic/Latino Ethnicity	**n = 2**
Mexican/Mexican American/Chicano	50%
Central American	-
Puerto Rican	50%
South American	-
Another Hispanic/Latino ethnicity	-
Non-Hispanic/Latino Ethnicity	**n = 3**
Asian Indian/South Asian	67%
Chinese	33%
Another non-Hispanic/Latino ethnicity	-
Primary Language*	**n = 302**
English	99%
Spanish	<1%
Indigenous	-
Both English and Spanish	<1%
Another Language	-
Age Groups	**n = 302**
0-15 years	-
16-25 years	-
26-45 years	-
46-59 years	-
60+ years	100%
Gender Identity	**n = 302**
Female	81%
Male	19%
Transgender	-
Gender queer	-
Questioning or Unsure	-
Another Gender Identity	-
Sex Assigned at Birth	**n = 302**
Female	81%
Male	19%
Sexual Orientation	**n = 28**
Heterosexual or straight	100%
Bisexual	-
Gay or Lesbian	-

Queer	-
Questioning or unsure of sexual orientation	-
Another sexual orientation	-
Veteran	**n = 302**
Yes	8%
Disability Status	**n = 293**
Yes	36%
Disability Type*	**n = 105**
Difficulty seeing	17%
Difficulty hearing, or having speech understood	4%
Another communication disability	-
Learning disability	1%
Developmental disability	1%
Dementia	2%
Another mental disability, not related to mental illness	3%
Physical/mobility disability	64%
Chronic health condition/chronic pain	36%
Another disability	4%

Figure 2 describes MASH enrollment. 106 clients who completed the initial BGS scored in Tier 1, indicating they were "thriving" and did not need further assessment. Of the remaining 196 clients eligible for follow-up with the next MASH assessment survey, 32 clients completed the initial R&R survey. Reasons eligible clients did not complete the R&R survey included not being able to be reached by program staff and declining to complete the survey.

Of the 32 clients who completed the initial R&R assessment, no clients fell into Tier 4 or crisis. For 15 clients, cases were stalled and eventually closed before recommendations could be presented due to being nonresponsive (i.e., unable to reach the client), noncompliant (i.e., canceling multiple appointments or unwilling to share necessary financial information), or no longer interested in MASH services.

Figure 2. MASH enrollment

A total of 36 clients have been discharged from MASH. Four clients completed exit BGS and R&R surveys after discharge. All these clients were English-speaking women who were experiencing a disability while half identified racially as White. Three of these clients completed interviews.

Evaluation Question 1

Does enrollment in the MASH program impact the client's motivation to change their housing situation, and if yes, to what degree?

The shifts in clients' responses to R&R survey questions concerning financial management and expense coverage suggest that MASH services encouraged clients to improve their financial affairs. In interviews, clients expressed feelings of empowerment because volunteers worked with them to "problem-solve" rather than taking over, enabling clients to have the final say on their financial decisions.

> "They kind of gave me suggestions on how I could handle paying bills and things like that, but pretty much it depended on how I was handling the situation, because I'm the one here, paying the bills, and it all that boils down to me and how I'm handling it."

Evaluation Question 2

Does the program improve a client's sense of security and safety and if yes, to what degree?

Client responses to R&R survey items and program reflections captured during interviews were utilized to determine how the MASH program affected clients' desire to alter their living circumstances. Changes in clients' perceptions of their safety, such as mobility issues or risk of falls, varied possibly due to the different medical issues they were managing. As MASH clients are often medically fragile or disabled,

their concerns about safety likely fluctuate based on the severity of their health conditions rather than the impact of program services. Interview data suggests the practical assistance and financial guidance provided through the MASH program increased clients' sense of security by improving their living conditions and financial stability. Clients also reported feeling more in control of their situations.

> "Just having somebody there that you can talk to helps to start with, because most people don't understand what you're talking about when you talk finances. Most people, they see me starting to work on, trying to figure out my bank account [and] they think you should turn it over to somebody else..."

Evaluation Question 3

Does enrollment in the program reduce feelings of depression, anxiety, and isolation and if yes, to what degree?

Examination of clients' BGS scores before and after participating in MASH implies the program had a positive impact on their emotional well-being, especially their feelings of loneliness. Client reflections on their MASH program experiences align as they consistently emphasized the emotional comfort, they received from having someone to talk to about their financial issues and personal hardships. Having a confidante who can provide a crucial social connection for MASH clients, helping them to manage their emotions and feel less alone.

> *"...just having somebody here to talk to and give me ideas...when you're alone, you just feel yourself talking. But when you get around other people, they feel you full of other ideas, so you can work on them and that just affects your whole outlook...that's what they did for me. They came in, they helped me, let me talk, let me share things, how I was feeling. And I'm very, very thankful that they were here."*

Evaluation Question 4

Does the program affect the enrolled client's housing situation, and if yes, how?

Interview data suggests MASH provided emotional support, financial advice like bill management, and practical aid in the form of essential household items that helped clients maintain a stable living environment and likely avoid future complications that might jeopardize their housing security.

Conclusions

Data from Year Two suggests that the MASH project is positively impacting clients' emotional well-being, security and safety, financial situations, and housing stability. The project has made strides toward developing a scalable workflow model by refining program processes and budget to tackle challenges in client outreach, engagement, intervention, and volunteer recruitment and retention. Additionally, CAREGIVERS has formed a collaboration of volunteer caregiving organizations, which will serve as a foundation for expanding the MASH program into other communities. In Year Three, MASH aims to broaden its reach and better support diverse older adults facing financial and housing instability throughout Ventura County.

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Appendix A. Demographics Form [Required for Individuals Served (per §3580.010)]

Demographic Information

Date_____

Your answers to the following questions will help Ventura County Behavioral Health understand who we are serving. The information on this form is private. **Please skip any questions you do not want to answer. Thank you!**

What is your payor source?

- ◻ Medi-Cal/Gold Coast
- ◻ Private Insurance (e.g. Kaiser, Blue Cross)
- ◻ Medicare (Age 65+)
- ◻ No Insurance

What racial categories do you identify with? Please select all that apply.

- ◻ American Indian or Alaska Native
- ◻ Asian
- ◻ Black or African American
- ◻ Hispanic or Latino
- ◻ Native Hawaiian or Pacific Islander
- ◻ White
- ◻ More than one race
- ◻ Another race (please specify): _____

What ethnic categories do you identify with? Please select all that apply.

Hispanic or Latino

- ◻ Caribbean
- ◻ Central American
- ◻ Mexican/Mexican American/Chicano
- ◻ Puerto Rican
- ◻ South American
- ◻ Another Hispanic or Latino ethnicity (please specify): _____

Non-Hispanic or Non-Latino

- ◻ African
- ◻ Asian Indian/South Asian
- ◻ Cambodian
- ◻ Chinese
- ◻ Eastern European
- ◻ European
- ◻ Filipino
- ◻ Japanese
- ◻ Korean
- ◻ Middle Eastern
- ◻ Vietnamese
- ◻ Another non-Hispanic or Latino ethnicity (please specify): _____

- ◻ More than one ethnicity

What is the primary language spoken in your home?

- ◻ Spanish
- ◻ English
- ◻ Both Spanish and English
- ◻ Indigenous (Mixtec or another)
- ◻ Another language (please specify): _____

Do you have a disability?
(Disability is defined as a physical or mental impairment or medical condition lasting at least 6 months that substantially limits a major life activity, which is not the result of a severe mental illness.)

□ Yes □ No

If you have a disability, please select all that apply.

□ Difficulty seeing
□ Difficulty hearing, or having speech understood
□ Another communication disability (please specify): _____
□ Learning disability
□ Developmental disability
□ Dementia
□ Another mental disability, not related to mental illness (please specify): _____
□ Physical/mobility disability
□ Chronic health condition/chronic pain
□ Another disability (please specify): _____

Are you a veteran? □ Yes □ No

How do you describe your gender?

□ Male
□ Female
□ Transgender
□ Genderqueer
□ Questioning or Unsure of your gender identity
□ Another gender identity (please specify): _____

What sex were you assigned at birth?

□ Male
□ Female
□ Another sex (please specify): _____

Do you consider yourself:

□ Heterosexual or straight
□ Bisexual
□ Gay or Lesbian
□ Questioning or Unsure of your sexual orientation
□ Queer
□ Another sexual orientation (please specify): _____

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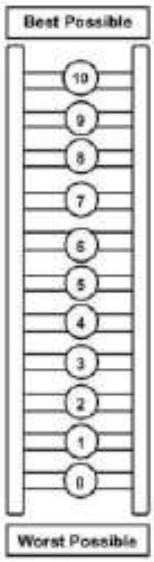
Appendix B. BetterAge Guidance System Questionnaire

Please **circle the answer** that best represents your response to the questions below.



For the first three questions please imagine a ladder with steps numbered from zero at the bottom to ten at the top. The top of the ladder represents the **best possible life for you** and the bottom of the ladder represents the **worst possible life for you.**

1. **On which step of the ladder would you say you personally feel you stand at this time?**

Worst possible										Best possible
0	1	2	3	4	5	6	7	8	9	10

2. **On which step do you think you will stand about five years from now?**

Worst possible										Best possible
0	1	2	3	4	5	6	7	8	9	10

3. **Now imagine the top of the ladder represents the best possible financial situation for you, and the bottom of the ladder represents the worst possible financial situation for you. Please indicate where on the ladder you stand right now.**

Worst possible										Best possible
0	1	2	3	4	5	6	7	8	9	10

4. **In general, how would you rate your physical health?**

Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

5. **How would you rate your overall mental health?**

Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

6. **For at least the past 6 months, to what extent have you been limited because of a health problem in activities people usually do?**

Not limited at all										Severely limited
0	1	2	3	4	5	6	7	8	9	10

7. **I have a sense of direction and purpose in life.**

Strongly disagree										Strongly agree
0	1	2	3	4	5	6	7	8	9	10

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8. **How often do you feel lonely?**

Never										Always
0	1	2	3	4	5	6	7	8	9	10

9. **How would you describe your sense of belonging to your local community?**

Very weak										Very strong
0	1	2	3	4	5	6	7	8	9	10

10. **If you were in trouble, do you have relatives or friends you can count on to help you whenever you need them, or not?**

Never										Always
0	1	2	3	4	5	6	7	8	9	10

11. **During the past two weeks, how often have you experienced positive emotions such as joy, affection, or hope?**

Never										Always
0	1	2	3	4	5	6	7	8	9	10

12. **During the past two weeks, how often have you experienced negative emotions such as sadness, worry, or despair?**

Never										Always
0	1	2	3	4	5	6	7	8	9	10

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Appendix C. Risk Assessment & Referral Form

Managing Assets for Security and Health (MASH)

Risk Assessment and Referral (R&R)

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Client Name: _____
Date: _____
MASH Unit Lead: _____
Office Team Lead: _____

Managing Assets for Security and Health (MASH)
Risk Assessment and Referral (R&R)

Date: _____
Client ID: _____
AWC Score (Q3): _____ **AWC:** *(5-6 Surviving; 3-4 Struggling; 0-2 Crisis)*
R&R Score: _____ **R&R:** *(Higher scores mean a greater concern)*
Tier Placement: _____

Tier One: Thriving/Self-resolve/Education (0-6)
Tier Two: Surviving/Financial Management (7-15)
Tier Three: Struggling/Housing Gap/Clinical Services Referral (16-20)
Tier Four: Crisis/External Intervention Services (21-27)

1. Does someone other than you manage your money?

☐ Yes (1) If yes, who is the person (sister, son, etc.) _____
☐ No (0)

2. Please select your ability to pay the following costs per month in the table below.
Select one response for each row. See Expense and Debt reports for details.

Ability to pay...	Unable to pay this (3)	Able to pay some of this (2)	Can pay this with little or no money left (1)	Can pay this with money left over (0)	Not applicable (0)
your rent or mortgage					
for groceries that you need					
your utility bills					
your debt, such as credit card bills					

3. How often are you behind on rent or mortgage?

☐ Every month (3)
☐ Four or more times a year (2)
☐ One to three times a year (1)
☐ Never (0)
☐ Unsure (0)

4. How confident are you with managing your money e.g., balancing a checkbook, making financial decisions?
Please circle a number.

Not Confident				Extremely Confident
4	3	2	1	0

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Funding for this Innovation Grant provided by

Client Name: _____
Date: _____
MASH Unit Lead: _____
Office Team Lead: _____

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5. Do you have a needed major expense that you are putting off due to costs?
(e.g., roof, plumbing, medical, car repairs)? See Expense report for details.

☐ Yes (1)
☐ No (0)

6. Would you like a professional to talk with you about your finances?

☐ Yes (1)
☐ No (0)

7. Does anyone put pressure on you to spend money or give them money?

☐ Yes (1)
☐ No (0)

8. Considering your current health, to what degree do you worry about your safety e.g., falls, mobility.

Worry Often				Do Not Worry
4	3	2	1	0

R&R Score: _____

(Higher scores mean a greater concern)

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Appendix D. Data Log Screenshots

Activities Tracking

Provider Name: Outreach and Engagement Provider	MASH	**Directions:** Fill out requested information or Place a number 1 in each relevant column to represent yes leave blank for no or n/a				Numbers Reached / Engaged	Event Time	Activity La	
Activity Name (May be contractual activities also)	Type of Activity (dropdown)	Additional Title / Topic / Info (if needed)	City	Zip Code	Date of Activity	Total Number of Participants (Those present.)	Length of Time of Activity (hours)	Activity was in Spanish	Activity was in English
Totals					0	0	0	0	0

Monthly Progress Report

Provider Name	MASH
Project Name	MASH

Directions: This is a fillable Excel form. Type or copy and paste answers below:

Challenges	Status	Date Completed

Successes	Status	Date Completed

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Appendix E. Interview Protocol

Managing Assets for Security and Health (MASH) Project

Client Interview Protocol

Thank you for taking the time to talk with me today. My name is _____, and I work for EVALCORP. Ventura County Behavioral Health has contracted with EVALCORP, an established applied research and evaluation consulting firm, to conduct an evaluation of the Managing Assets for Security and Health project, also known as MASH.

The purpose of this interview is to learn about the program benefits and ways that it can be improved. I expect this conversation to last no more than 30 minutes.

Your participation is voluntary. Your identity will be kept confidential, and your input will be shared anonymously. That means nothing you say will be personally linked to you in any reports that result from this key informant interview. All the comments today will be put together as a summary, and your name will not be tied to any information. Do you have any questions before we begin?

The Interview

The CAREGIVERS program provides many types of services. The MASH program is specifically focused on helping seniors improve their financial situation and to help lower their risk of losing their housing. Therefore, the questions that I am going to ask today specifically focus on those areas—financial and housing stability.

1. Please tell me about your engagement with the MASH program in terms of your housing situation.
   a. Did you feel you needed assistance? If so, what assistance did you need?
   b. Did the MASH team address those needs? If so, how?
   c. Did you have any needs that were not addressed? If so, please explain.
2. Has your housing situation changed since beginning the MASH project?
   a. How has it changed? Did the MASH team help you? Please explain.
3. Has your financial stability changed since beginning the MASH project?
   If yes…
   a. How has it changed? Did the MASH team help you? Please explain
   If no….
   a. What would you like to have changed that did not change?
   b. Did you discuss that issue with the MASH team? If yes, what was their response?
4. Now, let's talk about the collaboration between you and the MASH team.
   a. Has communication been effective?
   b. Have you had opportunities to speak up and share ideas?
   c. Did you feel comfortable with the process?
5. What do you see as the successes of MASH?
6. How can the MASH program be improved?
7. Is there anything else that you would like to share about the MASH program?

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Appendix F. Quarterly Report Template

Innovation Quarterly Progress Report

Date report completed:

Reporting period (enter the Quarter and the Year of the reporting period):

Name of person completing report:

Email Address:

Organization:

Guidance for Completing the Quarterly Progress Report

The guidance document will help you summarize the activities and accomplishments attained during the reporting period. The purpose of this document is to accurately and comprehensively communicate the program activities to Ventura County Behavioral Health conducted during the reporting period

This guidance document has seven sections:

1. Major Activities and Accomplishments
2. Problems (Challenges)
3. Successes (Stories)
4. Significant Findings *(Not Applicable for the Year 1 Qtr 1 Report)*
5. Dissemination and Marketing Activities
6. Additional Activities
7. Activities Planned for Next Reporting Period

Responses can be typed directly into this document. **The quarterly reports are due on the following dates:**

- **1/30 (covers October 1 through December 31)**
- **4/30 (covers January 1 through March 31)**
- **7/30 (covers April 1 through June 30)**
- **10/30 (covers July 1 through September 30)**

Quarterly reports should be emailed directly to MHSA staff hilary.carson@ventura.org, and EVALCORP evaluator lritter@evalcorp.com.

Major Activities and Accomplishments

Use this section to report on activities conducted during the reporting period in preparation and implementation of providing services, such as providing dinners, engaging in field trips, and youth leader

engagement. Your responses should correspond to the timeline, core deliverables, and outputs in your proposal and contract documents.

Provider Response [Insert your response here]:

Core Deliverable (From Contract)	Updates	Status
1.		
2.		
3.		

Problems (Challenges)

Describe any changes in the original project design or stated plans from your last quarterly report for the reporting period including any adjustments in task completion dates and special challenges (if any) encountered or expected during this reporting period. Include details about impacts to programming such as closures due to COVID-19 pandemic or staff changes. Please also use this section to advise your program administrator of any program needs that may require technical assistance.

Provider Response [Insert your response here]:

Successes (Stories)

Describe any project successes. For example, share a story about something they did or changed as a result of the program? Did you hold your first workshop?

Provider Response [Insert your response here]:

Significant Findings

Please attach an addendum with any significant findings from your project work that have been compiled, analyzed, or summarized- in this space any actions towards this end goal. If you have questions about what to include or report here please reach out for technical assistance prior to the report due date.

Provider Response [Insert your response here]:

Dissemination and Recruitment Activities

Please detail any dissemination activities, such as presenting the program successes at a school. Also include recruitment and marketing efforts during the reporting period in preparation for starting services, including activities such as community outreach, website development, social media, flyers, or radio advertisements. Please include an update on recruiting new youth. Copies of any new materials should be attached.

Provider Response [Insert your response here]:

Additional Activities

Use this section to address other planning preparations during the reporting period, including how you have shared information about your program with your community, brought partners together, or completed subcontracts or Memorandums of Understanding (MOUs). Please also detail your staffing activities, including the recruitment and hiring of new staff, as well as training new and existing staff.

Provider Response [Insert your response here]:

Activities Planned for the Next Reporting Period

Describe activities planned for the next reporting period, such as your continued planning period activities and the expected date to begin services.

Provider Response [Insert your response here]:

Appendix B: Community Program Planning Process (CPP)

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February 2025

COMMUNITY PLANNING PROCESS (CPP)

Three Year MSHA Annual Plan Update

What is MHSA?

California's Mental Health Services Act (MHSA), also known as Proposition 63, placed an additional 1% tax on personal incomes exceeding $1M.

- MHSA funds mental health programs across treatment, prevention and early intervention, innovation, infrastructure, and workforce development.
- There are five "buckets" of MHSA funding:

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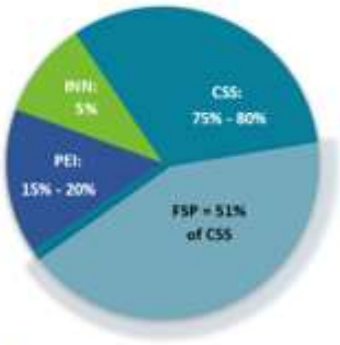
Annual Update and 3-year plan

Community Planning: Counties are required to meaningfully involve stakeholders in program planning (e.g., Annual Updates, Three-Year Plans), implementation, evaluation, and budget allocation

3 Year Plans: Outlines the department needs, goals, program plans and spending for the next three years.

Annual Update Reports: Reports on all MHSA funded programs from the prior fiscal year and anticipated changes for the next year always links back to the current 3-year plan.

-**Today's Purpose:** Annual Update



Required break down of spending

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What does the Annual Update Process look like?

Changes to the current 3YP - Community Planning Process

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Things to keep in mind

1 year remaining to allocate and spend MHSA funding of this Three-Year Plan 2023-2026

All MHSA money is being planned for as one time (i.e., infrastructure, time-limited expansions, pilot programs, trainings)

Prop 1 potential Impacts

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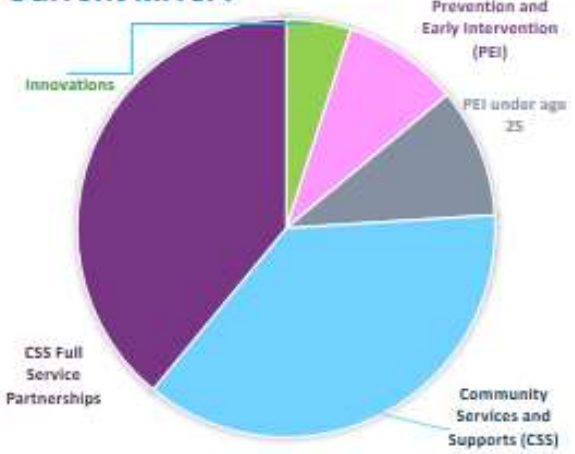
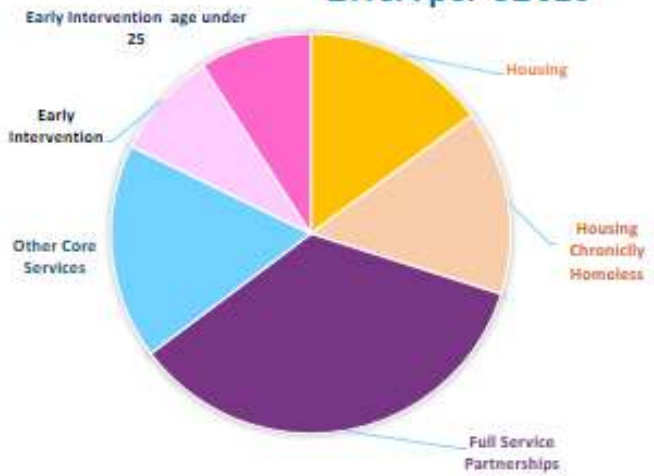
PROPOSITION ONE

Prop 1 Updated Spending Percentages

Current MHSA



BHSA per SB326



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Modernizing Our Behavioral Health System - California Health and Human Services

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Prop 1 the Behavioral Health Services Act (BHSA)

Prop 1: SB326 passed March 2024 along with the bond measure contained in AB531

Non comprehensive summary:

- Establishes a new 30% housing component with a housing first requirements
- Establishes the BHSA as a new source of funding for SUD services
- Creates a new and comprehensive structure for planning, data gathering, and reporting.
- Overhauls the adult and children's system of care statutes
- Eliminates county-based prevention funding
- Establishes new EBP service requirements (e.g., ACT/FACT and IPS Supported Employment)

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What does this mean for us?

- The county is currently redesigning programs to fit and fall under the new parameters, updates to come next year
- Additional housing and housing supports for individuals with behavioral health disorders coming to Ventura County
- Several new evidence-based programs will be available in FY 26-27 for our community

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UPDATES

Hand out

Refresher: Solutions to Need Assessment Result

I. **Housing**
   I. Buildings
   II. Services
   III. Units

II. **Expansion of Services and Treatment types**
   I. Staff
   II. Buildings
   III. Services

III. **Access**
   I. Timing
   II. Immediate or Urgent Care

IV. **Outreach and Education**
   I. Knowing when, where, and how to access services.

V. **Alternatives to VCBH**
   I. Mild to moderate care
   II. Services partners

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Febrero de 2025

PROCESO DE PLANIFICACIÓN COMUNITARIA
(CPP, POR SUS SIGLAS EN INGLÉS)
Actualización anual del plan de tres años de la MSHA

¿Qué es la MHSA?

La Ley de Servicios de Salud Mental de California (MHSA), también conocida como la Proposición 63, gravó un impuesto adicional del 1% sobre los ingresos personales superiores a un millón.

- La MHSA financia programas de salud mental para el tratamiento, la prevención, la intervención temprana, la innovación, la infraestructura y el desarrollo de la fuerza laboral.
- Hay cinco "pilares" del financiamiento de la MHSA:

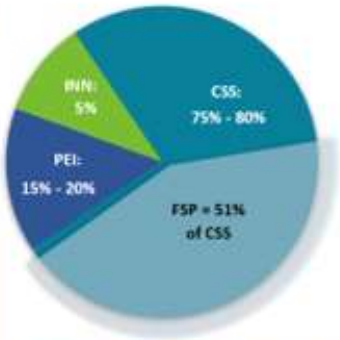
Actualización anual y plan de 3 años

Planificación comunitaria: se requiere que los condados involucren significativamente a las partes interesadas en la planificación del programa (por ejemplo, Actualizaciones Anuales, Planes de Tres Años), la implementación, la evaluación y la asignación de presupuesto.

Planes de 3 años: describen las necesidades del departamento, las metas, los planes del programa y los gastos para los próximos tres años.

Informes de actualización anual: los informes sobre todos los programas financiados por la MHSA del año fiscal anterior y los cambios anticipados para el próximo año siempre se vinculan con el plan de 3 años actual.

-**Objetivo de hoy:** actualización anual



Desglose de gastos necesario

¿Cómo es el proceso de ajuste de mitad de año?

Construcción sobre el Proceso de Planificación Comunitaria del Plan de 3 Años actual

Cosas para tener en cuenta

1 año restante para asignar y gastar los fondos de la MHSA de este plan de tres años de 2023-2026

Todo el dinero de la MHSA se planea una sola vez (es decir, infraestructura, expansiones de tiempo limitado, programas piloto, capacitaciones)

Prop. 1: impactos potenciales

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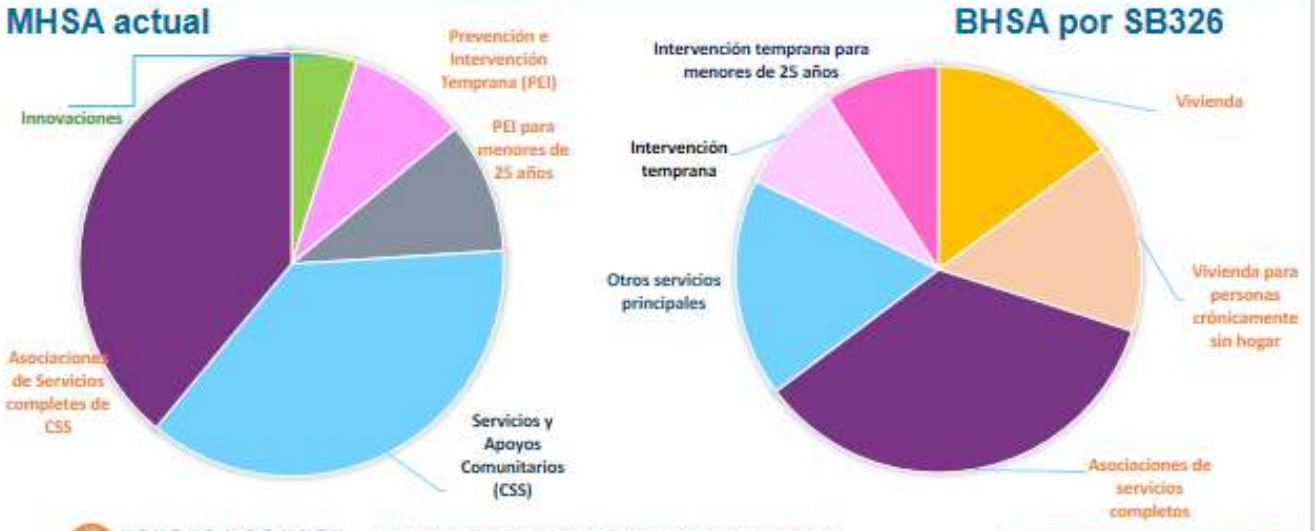
PROPOSICIÓN 1

Prop. 1: Porcentajes de gasto actualizados



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Modernizando nuestro Sistema de Salud Conductual - Salud y Servicios Humanos de California

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Prop. 1: La Ley de Servicios de Salud del Comportamiento (BHSA, por su designación en inglés Behavioral Health Services Act)

Prop. 1: SB326 se aprobó en 2024 junto con la emisión de bonos contenida en AB531.

Resumen no exhaustivo:

- Establece un nuevo componente de 30 % de vivienda con requisitos de una primera vivienda.
- Establece la BHSA como una nueva fuente de financiamiento para los servicios de trastornos por consumo de sustancias (SUD, por sus siglas en inglés).
- Crea una estructura nueva y completa para la planificación, la recopilación de datos y la generación de informes.
- Revisa los estatutos del sistema de cuidado de adultos y niños.
- Elimina el financiamiento de prevención basado en el condado.
- Establece nuevos requisitos de servicio de EBP (ej.: ACT/FACT y Empleo Respaldado por IPS)

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¿Qué significa esto para nosotros?

El condado está actualmente rediseñando programas que entren en los nuevos parámetros. Más actualizaciones el próximo año.

El Condado de Ventura contará con vivienda y apoyo adicional de vivienda para personas con enfermedades mentales graves.

Varios programas nuevos basados en evidencia estarán disponibles en el año fiscal 2026-2027 para nuestra comunidad.

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ACTUALIZACIONES

Folleto

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Actualización Resultado de la evaluación sobre soluciones a las necesidades

I. **Vivienda**
   I. Edificios
   II. Servicios
   III. Unidades

II. **Expansión de Servicios y tipos de tratamiento**
   I. Personal
   II. Edificios
   III. Servicios

III. **Acceso**
   I. Plazos
   II. Atención inmediata o urgente

IV. **Alcance comunitario y educación**
   I. Saber cuándo, dónde y cómo acceder a los servicios.

V. **Alternativas para VCBH**
   I. Cuidados leves a moderados
   II. Asociaciones de servicios

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Cambios en el plan de 3 años – Revisión del folleto

Dos tipos de actualizaciones reportadas en este folleto

11 proyectos sobre los que aún no se ha informado pero que se están poniendo en marcha según lo previsto

29 proyectos que están cambiando de alguna manera

Los proyectos que se actualizaron el año pasado se han eliminado según lo previsto o se reportan en el informe de actualización anual según lo previsto

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Pensamientos de la comunidad

¿QUÉ PIENSA?

¿QUÉ NOS FALTA?

Háganos saber

- Levante la mano ahora
- Envíe a través de MHSA@ventura.org
- ¡Incluya sus comentarios en sus encuestas!

Revisión y próximos pasos

1. Continamos recibiendo comentarios
   - Fecha límite: 28 de marzo
2. Publicamos el informe de ajuste para el público
   - BHAB y sitio web
   - Período de revisión pública: abril-mayo
3. Audiencia Pública para el plan de 3 años de la MHSA con ajuste a mitad de año
   - Lunes 19 de mayo de 2:00 P. M. a 3:30 P. M.

Las fechas están planificadas y sujetas a cambios.

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Por favor, conteste una encuesta

Inglés:
https://www.surveymonkey.com/r/24-25CPP-En

Español:
https://www.surveymonkey.com/r/24-25CPP-Sp

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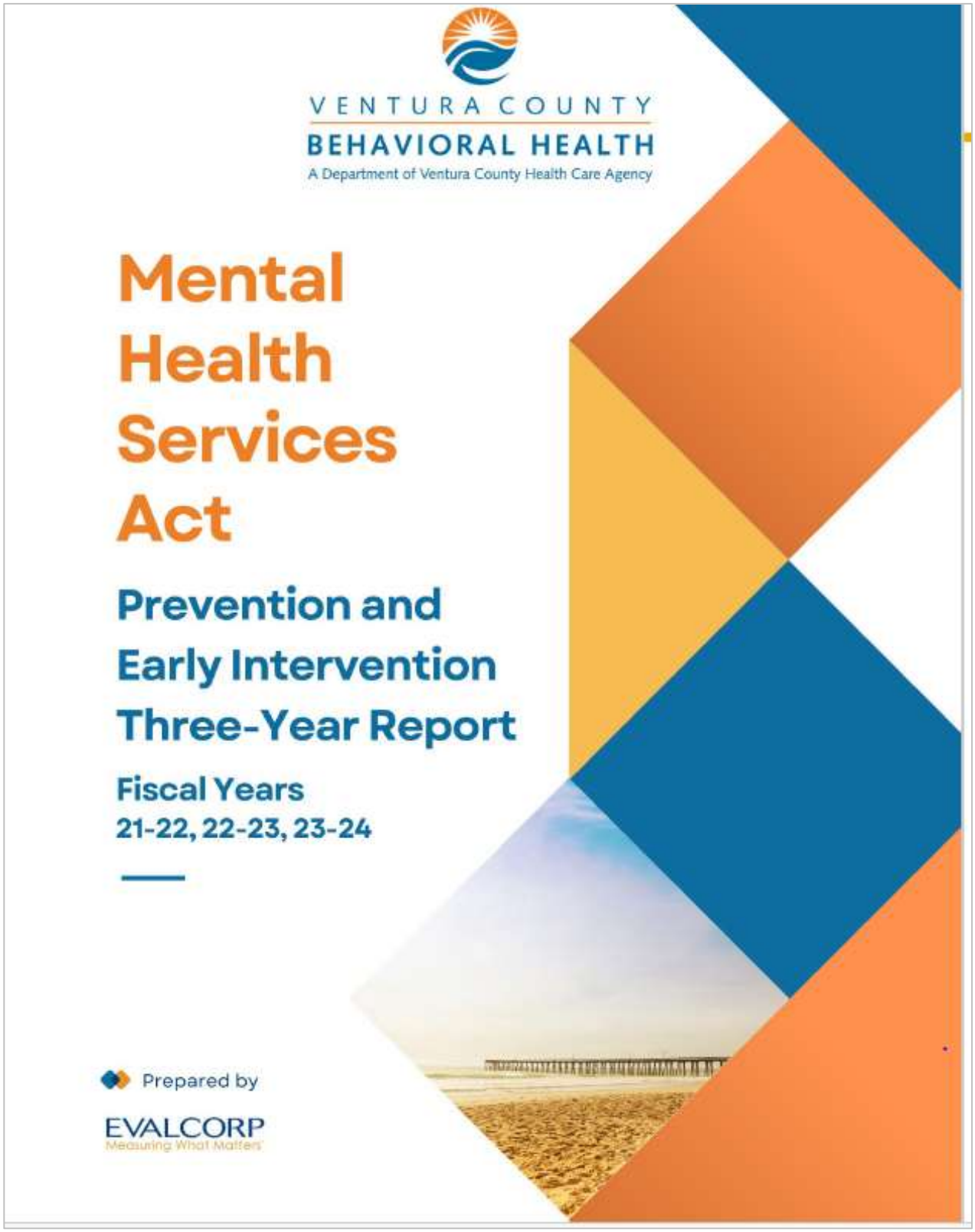
Appendix C: 3 Year VCBH_PEI Evaluation Report_Draft in Full



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ACKNOWLEDGMENTS

EVALCORP would like to acknowledge a number of individuals who contributed their time and input to support the development of this report. First, we thank Ventura County Behavioral Health for their partnership throughout the evaluation process. We mainly thank the Mental Health Services Act (MHSA) Team. We greatly appreciate their collaboration and support. We also want to thank all the funded providers for their hard work collecting the data presented in this report. Lastly, we want to acknowledge the program participants for completing evaluation surveys and sharing their experiences, stories, and recommendations. This report would not be possible without them.

INTRODUCTION

Overview

The Mental Health Services Act (MHSA) was approved in 2004 and enacted in 2005 through the passage of California's Proposition 63, which placed a 1% personal tax on incomes over $1 million to increase mental health funding in the state. The goal of MHSA is to transform "the mental health system while improving the quality of life for Californians living with a mental illness."* MHSA utilizes several components to accomplish this goal including one devoted to supporting programs that focus on Prevention and Early Intervention (PEI).

Ventura County Behavioral Health (VCBH) funded 21 programs using PEI dollars during fiscal years (FY) 2021-2022, 2022–2023, and 2023-24. The programs were delivered by community-based providers. These programs served children and adults, individuals and families, and trained providers who work with the County's diverse populations.

PEI Regulations

The state legislature and the Mental Health Services Oversight and Accountability Commission (MHSOAC) frequently update MHSA regulations. The most recent update was made in January 2020. The programs funded during FYs 2021-2022, 2022–2023, and 2023-24, and the data presented in this report, are aligned with both the PEI regulations and any amendments to the extent possible.

Since FY 2016–2017, PEI-funded programs have been required to align with at least one of seven categories and employ three required strategies. Program categories and strategies are detailed below.

The program categories include:

- **Prevention:** A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build positive factors. Prevention Program services may include relapse prevention for individuals in recovery from a serious mental illness.
- **Early Intervention:** 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 negative outcomes that may result from untreated mental illness. Early Intervention Program services may include services to parents, caregivers, and other family members of the person with early onset of a mental illness, as applicable.
- **Outreach for Increasing Recognition of Early Signs of Mental Illness:** The process of engaging, encouraging, educating and/or training and learning from potential responders (family, school personnel, peer providers, etc.) about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness. Outreach for Increasing Recognition of Early Signs of Mental Illness Program services may include reaching out to individuals with signs and symptoms of a mental illness, so they can recognize and respond to their own symptoms.

* https://mhsoac.ca.gov/sil/new-tools-focus-on-transparency/. Retrieved January 8, 2025.

- **Access and Linkage to Treatment:** A set of related activities to connect children, adults, and seniors with severe mental illness, as early in the onset of these conditions as practicable, to medically necessary care and treatment including, but not limited to, care provided by county mental health programs (e.g., screening, assessment, referral, telephone help lines, mobile response).
- **Stigma and Discrimination Reduction:** 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 seeking mental health services, and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness and members of their families.
- **Suicide Prevention (optional):** Organized activities that the county undertakes to prevent suicide because of mental illness.
- **Improving Timely Access to Services for Underserved Populations (optional):** To increase the extent to which an individual or family member from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services.

The strategies include:

- **Improving Timely Access to Services for Underserved Populations:** See above definition.
- **Access and Linkage to Treatment:** See above definition.
- **Implementing Non-Stigmatizing and Non-Discriminatory Practices:** Promoting, designing, and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services, and making services accessible, welcoming, and positive.
- **Outreach for Increasing Recognition of Early Signs of Mental Illness (optional):** See above definition.

Regulations also require reporting on specific processes and outcome metrics, including the following.

- Unduplicated number of individuals/families served
- Participant demographics (age, race, ethnicity, primary language, sexual orientation, gender, disability status, veteran status)*
- Number and types of referrals to treatment and other services
- Timely follow-through on referrals
- Changes in attitudes, knowledge, and behaviors related to mental illness and help-seeking
- Reduced mental illness risk factors and/or increased protective factors
- Reduced symptoms of mental illness
- Improved mental, emotional, and relational functioning
- Reduced negative outcomes that may result from untreated mental illness including suicide, incarcerations, school failure or dropout, unemployment, homelessness, etc., as defined by the Welfare and Institutions Code (WIC) 5840

*Note that for a minor younger than the age of 12, programs are not required to collect demographic data on sexual orientation, current gender identity, and veteran status. Additionally, programs serving children younger than 18 years of age are only required to collect data to the extent permissible under applicable state and federal privacy laws.

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EVALUATION METHODOLOGY

Evaluation Approach

VCBH contracted with EVALCORP Research & Consulting to develop this report, which summarizes data for PEI programs funded during FYs 2021-2022, 2022–2023, and 2023-24. This report presents state-required metrics as available and other program-specific information collected by the PEI providers. The report also provides a comprehensive review of programs, including the following process and outcome measures.

- Participant demographics and populations served
- Program services and activities
- Service participation
- Program impacts and outcomes

Data Collection Instruments

In the context of ensuring the efficacy of PEI programs, this section articulates the systematic approach towards assessing the impact of these initiatives. Grounded in the guidelines set forth by the California Code of Regulations for the Mental Health Services Act (MHSA), our framework endeavors to understand the pathways through which PEI programs achieve their objectives.

PEI programs employ a variety of data collection instruments, based on the program category to measure the impact each program is having on clients. Instruments have been carefully selected and constructed to ensure alignment with the MHSA regulations and appropriateness for program operations. Methods employed include direct, indirect, and quasi-indirect measures of change, adapted to what is best suited for each individual PEI program.

For all Stigma and Discrimination Reduction programs, the California Code of Regulations calls for validated methods to measure changes in attitudes, knowledge, and/or behaviors related to mental illness or seeking mental health services for Stigma and Discrimination Reduction Programs. The Mental Help Seeking Attitudes Scale (MHSAS) is used to measure respondents' overall evaluation of their seeking help from a mental health professional if they find themselves dealing with a mental health concern (Hammer, Parent, & Spiker, 2018). Other Prevention or Early Intervention programs utilize the Schwartz Outcome Scale-10 (Schwartz & Michael, 2000) as an indirect measure of a broad domain of psychological health. These tools, among other constructed tools that meet the highest standards of survey item construction, provide insight into the impacts that PEI programs are having within the community.

Data Collection and Analysis

The evaluation employed a mixed-methods approach, utilizing quantitative and qualitative data provided to the county by PEI-funded programs. Although VCBH strives to standardize data collection across programs to the extent possible, variations existed in each program's specific data collection tools and measures to reflect program uniqueness and target populations; however, all data collection tools were designed to assess progress toward overarching PEI goals.

VCBH PEI-funded programs used five primary types of data collection strategies:

1) **VCBH Template**: In response to October 2015 PEI amendments, VCBH developed a comprehensive data collection spreadsheet to collect program implementation data and process metrics such as number of individuals served, participant demographics, service referrals, outreach and other program activities, and program successes and challenges. Since the template was launched in January 2017, VCBH has continued to tailor it to the needs of each PEI program and to increase the data's adherence to PEI regulations.

2) **Program Surveys**: Multiple PEI programs employ pre- and post-program surveys to collect outcome data required by the PEI regulations and additional information of interest to VCBH. The post-program surveys typically include both closed- and open-ended questions to capture participant attitudes, knowledge, and behaviors; participant risk and protective factors for mental illness; social-emotional well-being and functioning; symptoms of mental illness; participant satisfaction; and recommendations for improvements. Each PEI program uses different surveys to ensure that the data collected are relevant and appropriate to the individual programs. Since FY 2021–2022, VCBH has continued to streamline survey items across programs where appropriate.

3) **Narrative Reports**: When available, narrative reports provided by the PEI programs to VCBH describing key activities, successes, and challenges were reviewed and incorporated into the current report. Given that the program has evolved over the past three years and staff have actively addressed previous challenges, only feedback specific to the fiscal year 2023-2024 has been included.

4) **Electronic Health Record (EHR) Data**: Some PEI programs use the county's EHR system, SmartCare, to record client data including demographic information and treatment outcomes. This data source is more common among programs that do not use the VCBH template.

5) **Web Analytics**: A few PEI programs also use web analytics to measure reach and engagement on social media pages and websites.

Extensive data verification, cleaning, and analysis procedures were employed in preparing this report to ensure the accuracy and validity of the data and information presented.

Data Notes

Information about data availability and quality for individual PEI programs is presented within each program's section of the report. Notes about the overarching availability and quality of the data presented are listed below, and program results should be considered within the context of these limitations.

Data limitations for some PEI programs in FYs 2021-2022, 2022–2023, and 2023-24 included:

- **Duplicated data**: For some training programs, participants may attend more than one training, which could lead to duplicated data.

- **Missing data or "declined to answer" selections**: Some questions, particularly for demographic indicators, had low response rates, possibly due to discomfort with or misunderstanding of the question itself.
- **Low participation rates**: Not all participants completed outcome tools/follow-up surveys, and some programs had low numbers of participants.
- **Variations in data collection methods:** Different programs may have utilized varying methods or tools for collecting data across the past three years, which could result in differences in how data is reported or categorized.

VCBH continues to enhance data collection tools and procedures among the programs to report on demographics and outcomes according to PEI regulations. These efforts also emphasize cultural competence and inclusiveness, ensuring that the data reflects the diverse experiences and needs of all participants.

REPORT ORGANIZATION

This report presents the PEI data by program. The programs are organized into three core sections by their primary program categorization (Prevention, Early Intervention, and Other PEI Programs). All program category sections provide an overall summary of the program category and include an overview comprised of program descriptions, profiles of demographic characteristics of clients served, and highlighted successes and challenges experienced by programs within that category.

Each program's results are then presented, beginning with an overview of the program, followed by a detailed analysis of available data for fiscal years 21-22, 22-23, and 23-24. The type of data presented varies across programs but may include information about participant demographics, program activities and reach, referrals, participant outcomes, participant satisfaction, feedback and recommendations for program improvement, and success stories. Each program section also contains a conclusion and recommendations section. Process and outcome data are reported in alignment with State requirements whenever possible.

Appendix A delineates PEI-funded programs and their alignment with PEI Categories.

Appendix B provides an overview of PEI program participation, detailing the number of individuals served or trained by program and by region.

Appendix C offers insights into the effectiveness and collective impact of the Network Expansion Grants.

PREVENTION

The goal of the Prevention component of MHSA is to help counties implement services that promote wellness, foster health, and prevent the suffering that can result from untreated mental illness. In Ventura County, there are 11 programs primarily categorized under Prevention. These programs serve several historically underrepresented populations including Hispanics/Latinos, Transitional Age Youth (TAY), individuals who are Deaf and Hard of Hearing (DHH), and LGBTQ+. Program services vary but include support groups, workshops, trainings, education, and presentations.

Across programs, participants expressed high levels of satisfaction with the services they received. Additionally, programs serving underrepresented groups reached their intended priority population(s). The following pages outline further details about each program's population(s) served, activities and outreach, and participant outcomes.

Prevention programs offer activities to reduce risk factors for and build protective factors against developing a potentially serious mental illness. They may include relapse prevention for individuals in recovery from a serious mental illness. A total of 661,677 participants were served by Prevention programs in FYs 2021-2022, 2022–2023, and 2023-24.

Prevention Program Descriptions

Ignite – Catalyst Church: Provides trauma-informed education and counseling by offering workshops and one-on-one counseling to help participants understand and heal from the effects of ACEs, as well as community outreach and engagement to promote prevention strategies.

Mixteco Indigena Community Organization Project (MICOP): Facilitates mental health for the Latino and Indigenous communities through support groups and one-on-one support to manage stress and depression, as well as referrals and links to culturally and linguistically competent mental health providers, and outreach to promote awareness of mental health and existing services.

Multi-Tiered System of Support (MTSS), VCOE and LEA: Provides education and training for school personnel and students, as well as family outreach and engagement to reduce stigma and discrimination about mental illness throughout Ventura County.

Network Expansion Grants - Prevention: 11 of grants provided financial support to time-limited, community-based projects or programs using innovative approaches to reduce mental illness risk and promote well-being in underrepresented populations.

One Step A La Vez: Serves Latino, LGBTQ+, and TAY at risk of homelessness or in the juvenile justice system through outreach, a drop-in center, wraparound wellness, stress and wellness classes, a high school equality club, and LGBTQ+ support groups.

Program to Encourage Active, Rewarding Lives for Seniors (PEARLS): Offers an in-home counseling program for seniors that teaches participants how to manage depression through counseling sessions supported by follow-up phone calls.

Project Esperanza: Offers mental health service assistance, educational and wellness classes, and activities to Hispanic/Latino families in the Santa Paula community.

Promoviendo Program (Promotoras y Promotores Foundation [PyPF]): Facilitates mental health for immigrant Latinas/Hispanic women at risk of depression through support groups and one-on-one support to manage stress and depression, as well as referrals and links to culturally and linguistically competent mental health providers, and outreach to promote awareness of mental health and existing services.

Tri-County GLAD: Increases knowledge and awareness of mental health concerns in the Deaf and Hard of Hearing community through outreach, referrals, social media videos, presentations, and workshop.

Wellness Centers Expansion: Provides coordinated health/mental health and other support services to maximize student engagement and success through staff and student trainings, family engagement activities, screenings, referrals, and early intervention activities.

Wellness Everyday and STAY Media Campaign: Provides prevention, suicide prevention, and coping with trauma messaging via social media campaigns and their website.

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Program Highlights

Individuals received core program services†:

FY 21-22: 181,923
FY 22-23: 225,865
FY 23-24: 253,889

661,677

Individuals referred to mental health care and/or social support services†:

FY 21-22: 112,055
FY 22-23: 186,587
FY 23-24: 6,587

305,229

Individuals reached through other program activities:

FY 21-22: 94,331
FY 22-23: 84,696
FY 23-24: 68,222

247,249

†Number of individuals may be duplicated.

Prevention Programs: Demographics of Participants[§]

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Race*	**n = 842**	**n = 624**	**n = 1,164**
American Indian/Alaska Native	1%	0%	2%
Asian	1%	1%	2%
Black/African American	1%	1%	2%
Hispanic/Latino	62%	74%	73%
Native Hawaiian, other Pacific Islander	0%	0%	1%
White	31%	0%	21%
More Than One Race	2%	0%	3%
Other	2%	23%	1%
Declined to answer:	*35*	*24*	*15*
Ethnicity*	**n = 737**	**n = 532**	**n = 1,050**
Hispanic/Latino	**85%**	**89%**	**88%**
Caribbean	0%	0%	0%
Central American	2%	2%	2%
Mexican/Mex.-Am./Chicano	81%	84%	83%
Puerto Rican	0%	0%	1%
South American	1%	1%	1%
Other Hispanic/Latino	2%	2%	2%
Non-Hispanic/Latino	**15%**	**11%**	**26%**
African	1%	1%	1%
Asian Indian/South Asian	<1%	<1%	2%
Cambodian	0%	0%	0%
Chinese	<1%	<1%	0%
Eastern European	1%	1%	2%
European	11%	8%	16%
Filipino	<1%	0%	2%
Japanese	<1%	<1%	0%
Korean	0%	0%	0%
Middle Eastern	<1%	<1%	1%
Vietnamese	0%	0%	0%
Other Non-Hispanic/Latino	1%	1%	2%
More than one ethnicity	1%	1%	<1%
Declined to answer:	*106*	*84*	*106*

Prevention Programs: Demographics of Participants[§]

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Primary Language*	**n = 910**	**n = 708**	**n = 1,266**
English	36%	30%	46%
Spanish	53%	54%	56%
English and Spanish	--	--	0%
Indigenous	5%	8%	3%
Other	5%	7%	20%
Declined to answer:	*2*	*24*	*44*
Age Groups	**n = 849**	**n = 636**	**n = 1,261**
0-15 years	31%	20%	33%
16-25 years	9%	10%	22%
26-59 years	27%	33%	29%
60+ years	33%	36%	17%
Declined to answer:	*5*	*6*	*2*
Gender Identity	**n = 618**	**n = 659**	**n = 1,124**
Female	78%	80%	69%
Male	19%	20%	28%
Transgender	2%	0%	1%
Genderqueer	0%	0%	1%
Questioning or Unsure	1%	0%	1%
Another Gender Identity	1%	0%	0%
Declined to answer:	*33*	*50*	*3*
Sex Assigned at Birth	**n = 611**	**n = 563**	**n = 1,315**
Male	19%	20%	44%
Female	81%	80%	56%
Declined to answer:	*13*	*50*	*7*
Sexual Orientation	**n = 560**	**n = 479**	**n = 1,012**
Heterosexual or Straight	91%	94%	91%
Bisexual	3%	1%	6%
Gay or Lesbian	2%	1%	2%
Queer	1%	<1%	1%
Questioning or Unsure	1%	0%	1%
Another Sexual Orientation	3%	4%	1%
Declined to answer:	*67*	*41*	*62*

*Percentages may exceed 100% because participants could choose more than one response option.

§Demographic data was not collected for MTSS, Wellness Centers, or Wellness Everyday.

^Percentages and counts reflect the number of individuals who selected each Hispanic or Non-Hispanic Ethnicity.

Prevention Programs: Demographics of Participants[8]

City of Residence	n = 936	n = 724	n = 1,228
Camarillo	4%	3%	3%
Fillmore	17%	20%	22%
Moorpark	2%	1%	0%
Newbury Park	1%	1%	0%
Oak Park	0%	<1%	0%
Ojai	1%	1%	3%
Oxnard	22%	25%	25%
Piru	1%	1%	1%
Port Hueneme	2%	2%	2%
Santa Paula	35%	33%	25%
Simi Valley	3%	2%	2%
Thousand Oaks	2%	2%	2%
Ventura	10%	8%	11%
Other	1%	<1%	4%

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HEALING THE COMMUNITY
MIXTECO INDIGENA COMMUNITY ORGANIZING PROJECT (MICOP)

The Mixteco Indigena Community Organizing Project (MICOP) facilitates community-based mental health workshops for the Hispanic/Latino and Indigenous communities of Oxnard, El Rio, and Port Hueneme. The program raises awareness of mental health with a focus on the topic of depression and how it impacts Hispanic/Latino and Indigenous communities. MICOP provides culturally relevant holistic and traditional Indigenous wellness treatments to relieve symptoms of stress, anxiety, and depression. In addition, the program provides referrals and linkages to mental health providers and other culturally and linguistically appropriate services. MICOP also conducts outreach to the community to promote program services, distribute mental health educational information, and increase awareness of other local mental health resources.

Program Strategies

Improves timely access to services for underserved Hispanic/Latino and Indigenous communities in Oxnard, El Rio, and Port Hueneme through referrals to culturally and linguistically appropriate services

Implements non-stigmatizing and non-discriminatory practices by providing culturally relevant Indigenous wellness treatments and workshops, as well as offering cultural competency training to local service providers.

HEALING THE COMMUNITY

Program Highlights
HEALING THE COMMUNITY

Demographic Data

MICOP collects unduplicated demographic data from the individuals they serve. This section presents information from 432 individuals who completed a demographic form over the past three years.

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Race*	**n = 141**	**n = 142**	**n = 139**
American Indian/Alaska Native	1%	0%	2%
Asian	1%	0%	1%
Black/African American	0%	0%	1%
Hispanic/Latino	89%	99%	98%
Native Hawaiian, other Pacific Islander	0%	0%	0%
White	3%	0%	1%
More Than One Race	6%	1%	1%
Other	6%	0%	1%
Ethnicity*	**n = 146**	**n = 142**	**n = 140**
Hispanic/Latino			
Caribbean	0%	1%	0%
Central American	1%	0%	1%
Mexican/Mex.Am./Chicano	92%	96%	96%
Puerto Rican	0%	0%	1%
South American	0%	0%	0%
Other Hispanic/Latino	5%	5%	1%
Non-Hispanic/Non-Latino			
African	0%	0%	0%
Asian Indian/South Asian	0%	0%	0%
Cambodian	0%	0%	0%
Chinese	0.5%	0%	0%
Eastern European	0%	0%	0%
European	0.5%	1%	0%
Filipino	0%	0%	0%
Japanese	0%	0%	0%
Korean	0%	0%	0%
Middle Eastern	0%	0%	0%
Vietnamese	0%	0%	0%

Other Non-Hispanic/Non-Latino	1%	1%	1%
More than one	1%	0%	0%

HEALING THE COMMUNITY

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Primary Language*	**n = 146**	**n = 143**	**n = 140**
English	25%	12%	29%
Spanish	73%	78%	86%
English and Spanish	--	--	0%
Indigenous	39%	31%	17%
Age Groups	**n = 145**	**n = 143**	**n = 140**
0-15 years	0%	0%	0%
16-25 years	11%	23%	20%
26-59 years	79%	69%	72%
60+ years	10%	8%	8%
Gender Identity	**n = 146**	**n = 143**	**n = 138**
Male	11%	14%	15%
Female	88%	86%	84%
Transgender	0%	0%	0%
Genderqueer	1%	0%	1%
Questioning or Unsure	0%	0%	0%
Another Gender Identity	0%	0%	0%
Sex Assigned at Birth	**n = 146**	**n = 143**	**n = 140**
Male	11%	14%	14%
Female	89%	86%	86%
Another Sex Assigned	0%	0%	0%
Sexual Orientation†	**n = 146**	**n = 142**	**n = 138**
Heterosexual or Straight	95%	98%	96%
Gay or Lesbian	2%	0%	1%
Bisexual	1%	1%	1%
Queer	1%	1%	1%
Questioning or Unsure	1%	0%	1%
Another Sexual Orientation	0%	0%	1%
Disability	**n = 146**	**n = 143**	**n = 140**
Yes	14%	10%	11%
No	86%	90%	89%

HEALING THE COMMUNITY

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Disability Type*	**n = 20**	**n = 18**	**n = 16**
Seeing	20%	22%	31%
Hearing	5%	0%	6%
Other Communication	5%	6%	6%
Learning Disability	10%	0%	13%
Developmental Disability	5%	6%	0%
Dementia	0%	0%	0%
Another Mental Disability	0%	44%	19%
Physical Disability	10%	0%	19%
Chronic Health Condition	30%	17%	25%
Another Disability	20%	6%	13%
Veteran Status	**n = 145**	**n = 143**	**n = 140**
Yes	1%	1%	0%
No	99%	99%	100%

*Total may exceed 100% because participants could choose multiple response options.

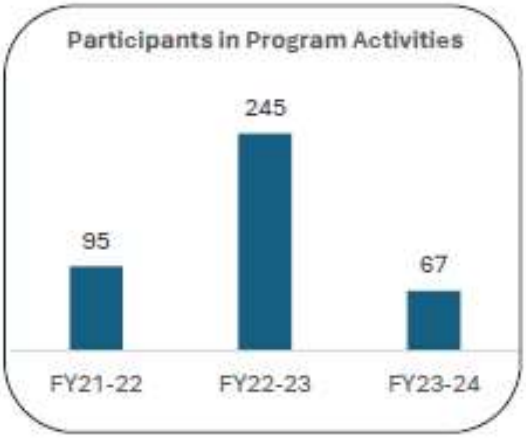
HEALING THE COMMUNITY

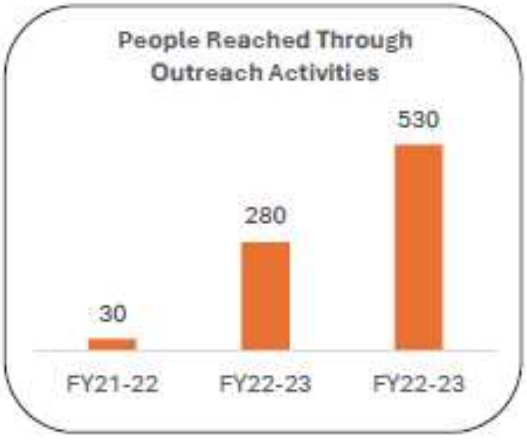
Program Activities & Outreach

Program activities include classes, meetings, support groups, trainings, and workshops facilitated by MICOP program staff. Program participants and other community members may participate in these activities and events. COVID greatly impacted the program in FY 21-22, and then in FY 22-23 participants in the program activities strengthened from 95 to 245 participants. Subsequently, in FY 23-24, based on participants' recommendations, participants receiving treatment decreased due to more treatments provided for each client, yielding fewer clients, and one conference was removed from the contract.

Activity Type	FY 21-22	FY 22-23	FY 23-24
Meeting	-	-	-
Training/Workshop	9	6	9
Support Group	8	11	10
Total Activities	**17**	**17**	**19**

Program Outreach Type	FY 21-22	FY 22-23	FY 23-24
Community Fair or Event	-	-	3
Presentation	1	1	-
Outreach/Outreach Misc.	-	2	4
Education	-	-	1
Other	-	-	2
Total Outreach Activities	**1**	**3**	**10**





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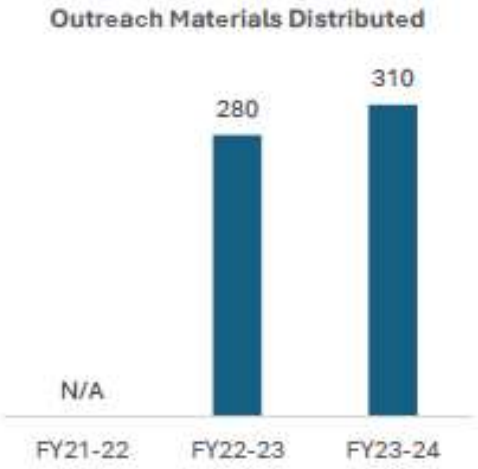
HEALING THE COMMUNITY

Program Activities & Outreach (continued)



From FY21-22 to FY23-24:

The number of participants in program activities initially increased but saw a decline in the past fiscal year[†]

The number of outreach materials distributed increased by 11% in the last fiscal year

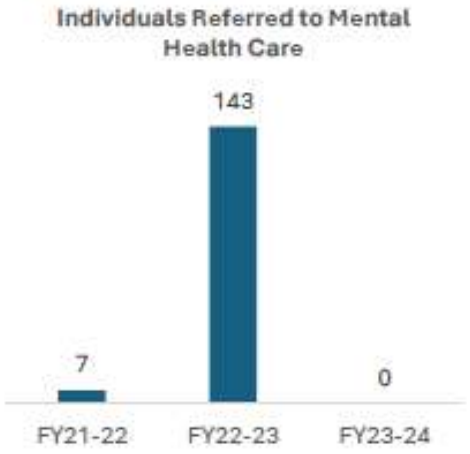
The percentage of activities and events offered in Spanish has been consistently ensured across all offerings

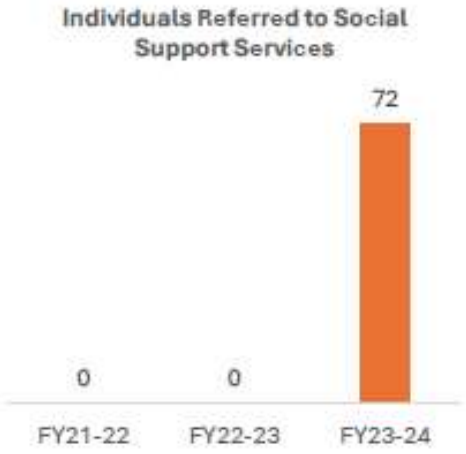
[†]Number of people reached may be duplicated because individuals could attend multiple activities/events.

HEALING THE COMMUNITY

Program Referrals

Program referrals include mental health care referrals to VCBH or other MHSA PEI or treatment programs. MICOP also provides referrals to social support services such as food, housing, health insurance, and other support services. The highlighted referral data represents unduplicated individuals who could be referred to multiple services.





HEALING THE COMMUNITY

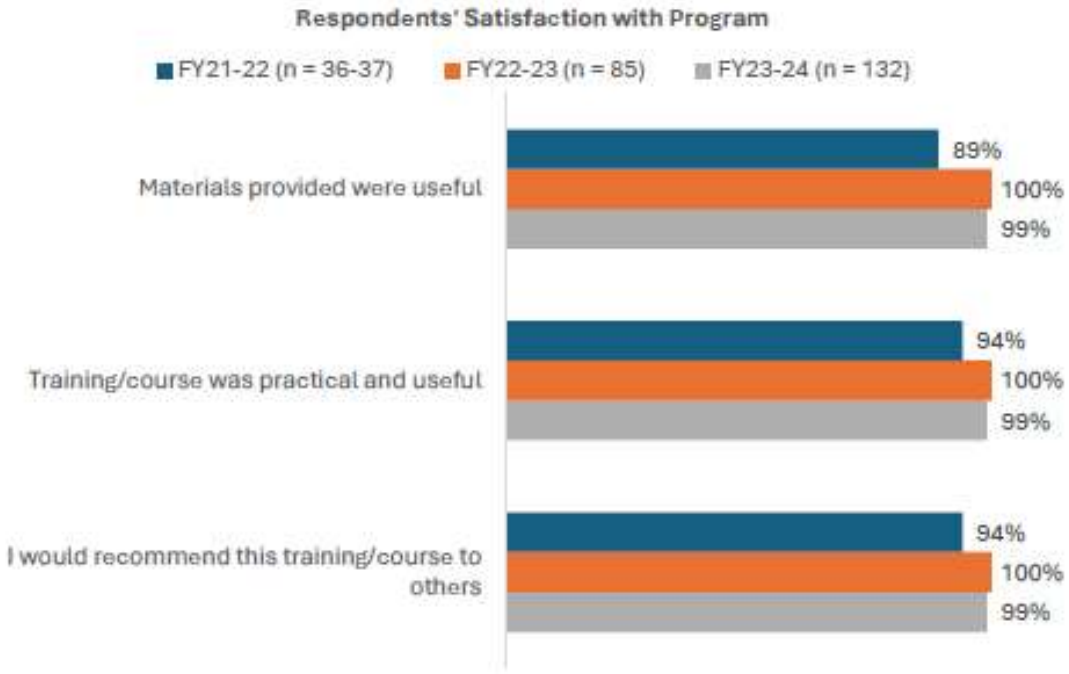
Program Outcomes

MICOP tracks program outcomes by asking participants to self-assess their knowledge from two perspectives (retrospective pre/post): before and after they receive services. In FY 21-22, participants reported an average difference of 65% in knowledge after receiving services. The data tool was revised after FY 21-22, and FYs 22-23 and 23-24 results are presented in the charts below.

HEALING THE COMMUNITY

Program Satisfaction

MICOP participants were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement for the past three years.



Most participants expressed complete satisfaction with MICOP's program.

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HEALING THE COMMUNITY

Areas of Support

Participants were asked to select areas where they needed additional support from a provided list of options.* The chart below highlights the top support areas identified over the past three years.

FY21-22 (n = 37)
- Mental health: **51%**
- Relationships with friends and family: **38%**
- Job situation: **27%**

FY22-23 (n = 80)
- Mental health: **99%**

FY23-24 (n = 119)
- Mental health: **98%**
- Relationships with friends and family: **8%**
- Parenting: **6%**

*Total percentage may exceed number of participants because they could choose more than one response option.

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HEALING THE COMMUNITY

Program Feedback

Participants who received program services from MICOP provided additional feedback through open-ended response questions. Their comments were categorized by theme, with the most common responses highlighted. Given that the program has evolved over the past three years, and staff has actively addressed previous challenges, only feedback specific to the fiscal year 2023-2024 is included in the chart below.

What was most helpful about this program?

- Participants valued the program's focus on self-care practices and appreciated the sense of community and safe space provided. They also valued the professionalism and expertise of the presenters , which contributed to a positive learning experience.

What would make this program better?

- Participants suggested activities that encouraged them to share the space and actively engage in or practice the proposed activities. They also recommended providing stress-relief tools, such as stress fidgets, to enhance comfort and focus during the program.

HEALING THE COMMUNITY

Conclusions and Recommendations

Over the past three fiscal years, MICOP has shown consistent engagement and impact among the Hispanic/Latino community. The number of individuals receiving services remained stable. Notably, outreach efforts expanded greatly, increasing the number of people from 30 in FY 21-22 to 530 in FY 23-24. This success in raising awareness demonstrates the program's commitment to connecting with the community and promoting its services, even as referrals to mental health and social support services fluctuated.

The program achieved a 100% satisfaction rate among respondents and notable increases in participants' confidence and awareness of mental health supports following training. However, the number of participants in program activities declined from 245 in FY 22-23 to 67 in FY 23-24 due to program changes. Fewer clients received more treatments. Additionally, while the demand for mental health support has increased, there has been a decrease in the need for assistance with relationships with friends and family. This shift in focus and priorities can inform future program efforts.

Exploring the reasons behind the decline in participation and referrals will be important to strengthening program outcomes. Gathering insights through focus groups or surveys can help identify any barriers participants encounter, allowing the program to adjust its strategies accordingly. Maintaining outreach efforts while regularly assessing community needs will help ensure MICOP stays relevant and effective.

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IGNITE CONOCIMIENTO
CATALYST CHURCH

Ignite Conocimiento at Catalyst Church in Ventura County is a community-driven program designed to address the lasting effects of Adverse Childhood Experiences (ACEs). With a focus on healing and resilience, the program provides a safe space for individuals and families to explore the emotional, mental, and physical impacts of ACEs. By integrating trauma-informed care with faith-based principles, Ignite Conocimiento offers a holistic approach to breaking cycles of trauma and promoting long-term well-being. Through a combination of educational workshops, counseling, and community engagement, the program empowers participants to overcome past adversities and build a foundation for healthier, more resilient futures.

Program Strategies

Provides trauma-informed education and counseling by offering workshops and one-on-one counseling to help participants understand and heal from the effects of ACEs.

Engages the community and promotes outreach by building strong community connections to create a support network and promote prevention strategies for families and local leaders.

Program Highlights

93 Individuals received core programs

512 Number reached through outreach events

16 Individuals referred to mental health care and/or social support services

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IGNITE CONOCIMIENTO
CATALYST CHURCH

Demographic Data

Ignite Conocimiento collects unduplicated demographic data from the individuals it serves. The data in this section represents information from 93 individuals who completed a demographic form in the past year.

Demographic Category	FY 23-24
Race*	**n = 26**
American Indian/Alaska Native	0%
Asian	0%
Black/African American	4%
Hispanic/Latino	85%
Native Hawaiian, other Pacific Islander	4%
White	8%
More Than One Race	0%
Other	0%
Ethnicity*	**n = 90**
Hispanic/Latino	
Caribbean	0%
Central American	0%
Mexican/Mex.-Am./Chicano	99%
Puerto Rican	0%
South American	0%
Other Hispanic/Latino	0%
Non-Hispanic/Latino	
African	0%
Asian Indian/South Asian	0%
Cambodian	0%
Chinese	0%
Eastern European	0%
European	1%
Filipino	0%
Japanese	0%
Korean	0%
Middle Eastern	0%
Vietnamese	0%
More than one	0%
Other Non-Hispanic/Latino	0%

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IGNITE CONOCIMIENTO
CATALYST CHURCH

Demographic Category	FY 23-24
Primary Language*	**n = 77**
English	70%
Spanish	30%
Indigenous	0%
Another Language	0%
Age Groups	**n = 92**
0-15 years	45%
16-25 years	55%
26-59 years	0%
60+ years	0%
Gender Identity	**n = 78**
Male	77%
Female	23%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%
Sex Assigned at Birth	**n = 79**
Male	77%
Female	23%
Sex Sexual Orientation	**n = 70**
Heterosexual or Straight	94%
Gay/Lesbian	0%
Bisexual	6%
Queer	0%
Questioning/Unsure	0%
Another sexual orientation	0%
Disability Status	**n = 59**
Yes	14%
No	86%

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IGNITE CONOCIMIENTO
CATALYST CHURCH

Demographic Category	FY 23-24
Disability Type*	**n = 8^**
Chronic Health Condition/Chronic Pain	0%
Dementia	0%
Developmental disability	13%
Difficulty Hearing, or having speech understood	0%
Difficulty Seeing	0%
Learning Disability	88%
Physical/Mobility Disability	0%
Another Disability	0%
Veteran	**n = 93**
Yes	0%
No	100%

*Total may exceed 100% because participants could choose multiple response options.

^Small sample sizes can make results less reliable and more affected by unusual values, so these findings should be interpreted cautiously.

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IGNITE CONOCIMIENTO
CATALYST CHURCH

Program Activities & Outreach

Program activities include classes, meetings, support groups, trainings, and workshops Ignite Conocimiento program staff facilitated. Program participants and other community members may participate in these activities and events.

Activity Type	FY 23-24
Community Service Activity	4
Dinner - General	28
Family Dinner	26
Field Trip	3
Parent Group	2
Summer Event	1
Training/Workshop	3
Youth Leader Meeting	4
Other	3
Total Activities	**74**

2,140 individuals participated in program activities

Program Outreach Type	FY 23-24
Community Fair or Event	2
Meeting	2
Outreach	1
Presentation	2
Total Outreach Activities	**7**

5 outreach events were conducted in Spanish

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IGNITE CONOCIMIENTO
CATALYST CHURCH

Program Referrals

Program referrals include mental health care referrals to VCBH or other MHSA prevention, early intervention, or treatment programs. Ignite Conocimiento also makes referrals to social supports such as food, housing, health insurance, and other support services.

8 participants were referred to mental health care

8 participants were referred to social supports

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IGNITE CONOCIMIENTO
CATALYST CHURCH

Program Outcomes

Ignite Conocimiento tracks outcomes for program participants (e.g., individuals who attend the drop-in center) using the Schwartz Outcome Scale (SOS-10), a 10-item measure of psychological health. Higher scores on this measure indicate greater psychological well-being and lower levels of distress. The chart below compares intake and exit scores.

Schwartz Outcome Scale (SOS-10)*		FY 23-24 Intake = 47, Exit = 39
Minimal	Intake	64%
	Exit	72%
Mild	Intake	17%
	Exit	23%
Moderate	Intake	19%
	Exit	5%
Severe	Intake	0%
	Exit	0%

More program participants had Minimal or Mild scores after the program:

Before: 81%

After: 95%

*Total score on the SOS-10 ranges from 0–60 and scores are categorized as minimal (40–59), mild (33–39), moderate (23–32), or severe (1–22) levels of distress.

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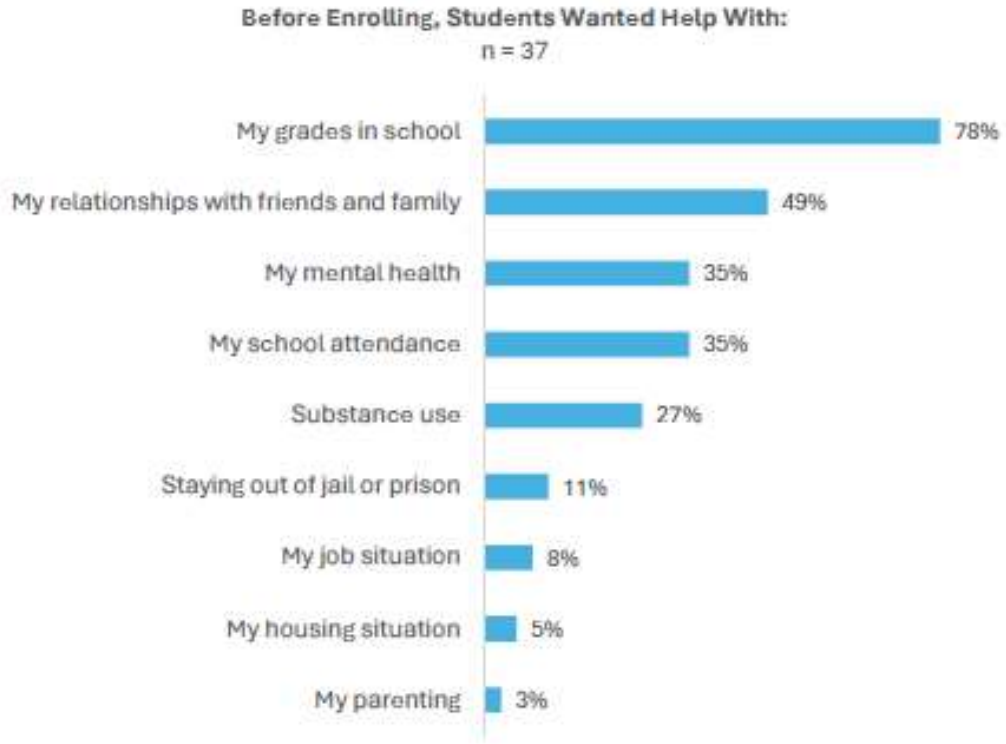
Program Outcomes

Ignite Conocimiento collected additional outcomes related to the kinds of help participants were looking for during FY23-24. The chart below displays these results.



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Program Satisfaction

To measure their satisfaction with Ignite Conocimiento, participants were asked to indicate the extent to which they disagreed or agreed with several statements about the program. The percentage of participants who agreed or strongly agreed with each statement is shown in the chart below.

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Program Feedback

Participants who received program services from Ignite were asked to provide additional feedback through two open-ended response questions. Their comments were categorized by theme, with the most common responses highlighted.

What was most helpful about this program?

- Participants highlighted the program's supportive and approachable staff, who foster a welcoming environment and a strong sense of community, often described as family. They valued the safe, positive space, which keep them engaged and provides emotional, mental health, and practical support, such as help with school work and life skills. Opportunities for social interaction and personal growth further enhanced the program's transformative impact.

What would make this program better?

- Participants suggested adding more field trips, particularly opportunities to explore places outside of town. Some recommended expanding the program's space and improving facilities, such as adding air conditioning. Other ideas included offering more guest speakers, opening on Mondays, and providing credits for hours at local schools.

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MULTI-TIERED SYSTEM OF SUPPORT (MTSS)
Ventura County Office of Education (VCOE)

The Multi-Tiered System of Support (MTSS) is a comprehensive framework designed to align academic, behavioral, and social-emotional learning initiatives within educational organizations, such as the Ventura County Office of Education (VCOE) and school districts, to identify and address student needs. By integrating these areas of support, MTSS benefits all students and fosters systemic change. VCOE, in coordination with contracted Local Educational Agencies (LEAs)/School Districts, implements several core activities countywide, including mental health screenings and referrals for students, education, and training for school personnel, family outreach and engagement, and ongoing technical assistance and contract monitoring.

Program Strategies

Provides access and linkage to services for those with serious mental illness and serious emotional disturbance.

Implements non-stigmatizing and non-discriminatory practices by providing culturally competent, evidence-based trainings to educators to support students from underserved and underrepresented groups.

Program Highlights‡

†This program did not provide demographic information.

IGNITE CONOCIMIENTO
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Conclusions and Recommendations

Ignite Conocimiento has demonstrated substantial success in fostering healing and resilience among participants affected by Adverse Childhood Experiences (ACEs). The program's trauma-informed, faith-based approach has created a safe, supportive environment, reflected in participants' high satisfaction levels and a marked improvement in distress scores. Serving primarily a Hispanic/Latino population, the program effectively addresses the needs of its target community in Ventura County. Participants highly value the supportive staff, sense of community, and holistic programming, identifying these as key strengths of the program.

To build on its strengths, the program could expand opportunities for enrichment by incorporating activities like field trips, inviting guest speakers, and providing additional academic support. Practical upgrades, such as improved air conditioning and expanded facilities, would further enhance participant comfort and accessibility. These enhancements, combined with the program's existing strong foundation, would enable Ignite Conocimiento to broaden its reach, strengthen its impact, and remain a vital resource for healing and resilience in Ventura County.

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MULTI-TIERED SYSTEM OF SUPPORT, VCOE

Program Activities

Program activities include screenings, referrals, early intervention services, and outreach events. County educators, students, and other community members may participate in these activities or events.

Activity Type	21-22*	22-23*	23-24*
Screenings	36,116	33,846	61,406
Referrals: Individual School-Based	27,977	23,195	22,942
Referrals: Group School-Based	7,628	7,051	8,851
Referrals: Community Based	1,177	1,390	1,126
Referrals: Other	16,570	11,254	24,871
Confirmed Linkage of Student/Family to Referral	11,842	2,067	1,419
Students Identified as At Risk	4,201	3,520	2,242
Calls to the VCBH Crisis Team	34	56	26
Early Intervention Services: Individual School-Based	34,130	177,781	34,075
Early Intervention Services: Group School-Based	94,544	25,011	85,062
Early Intervention Services: Safety Plans Developed	294	266	232
Early Intervention Services: Other	31,213	184,645	133,287
Staff and Student Trainings	1,540	1,640	3,002
Family Trainings and Outreach Events	146	335	609
Total Activities/Events	**267,364**	**472,034**	**379,118**

*These data are organized by school years, not fiscal years.

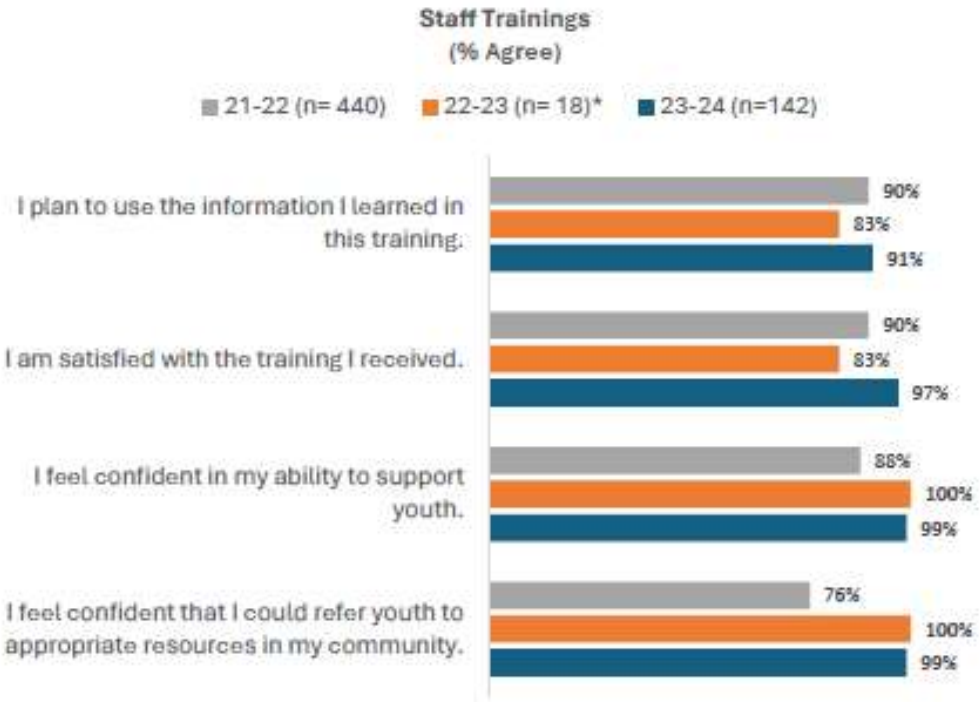
VCOE established Memorandums of Understanding (MOUs) with 12 Local Educational Agencies (LEAs)/School Districts to implement MTSS at all their school sites.

MULTI-TIERED SYSTEM OF SUPPORT, VCOE

Program Outcomes

Staff Training Outcomes

Trainings were provided to school personnel (teachers, counselors, specialists, administrators, and classified support staff) to increase Mental Health Awareness and reduce stigma and discrimination for those with mental illness or seeking mental health services. Participants of the trainings were asked for feedback on the trainings. The results below report only on the LEA-provided trainings.



*Data may be skewed due to a small sample size. Data collection efforts were modified in 23-24 to gather a more representative sample.

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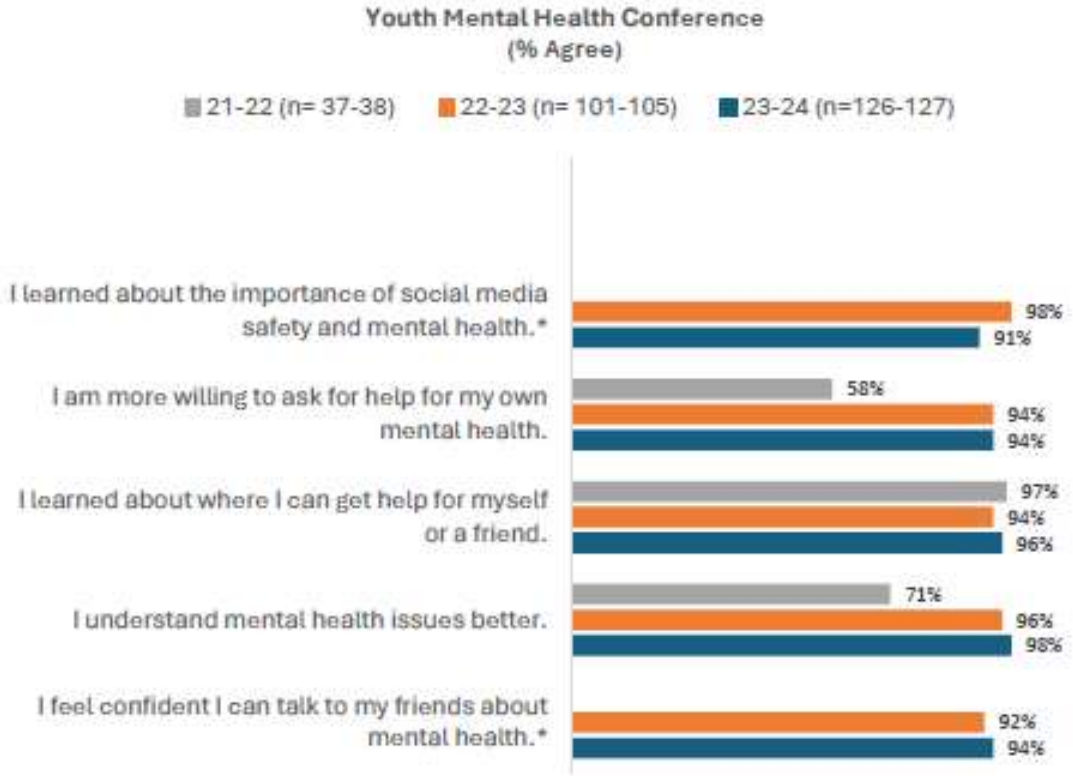
MULTI-TIERED SYSTEM OF SUPPORT, VCOE

Youth Mental Health Conference Outcomes

The annual Youth Mental Health Conference offers presentations and breakout sessions to high school students on various mental health and wellness topics. The two-day conference includes breakout sessions on sobriety, mental health stigma, and social media safety. Findings from post-training surveys are presented below.



*These questions were not asked in the 2021-2022 outcomes survey.

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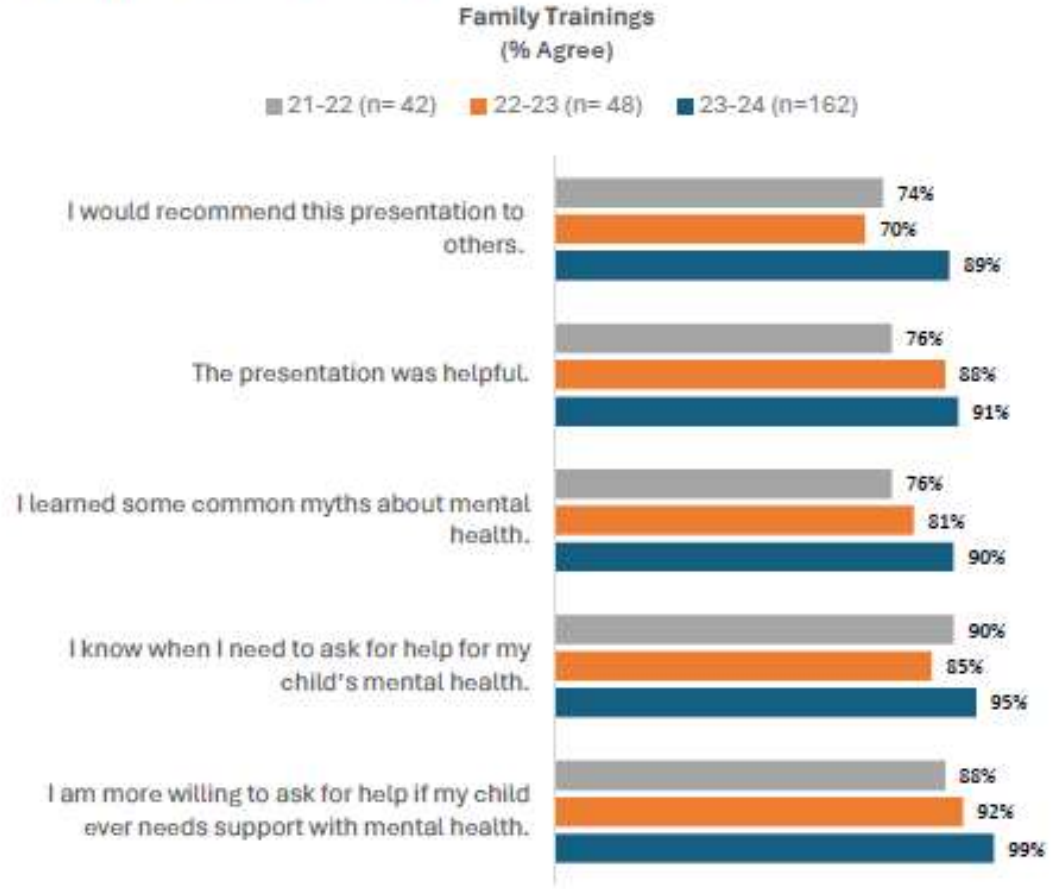
MULTI-TIERED SYSTEM OF SUPPORT, VCOE

Family Training Outcomes

Below is a summary of feedback from family members participating in mental health awareness and stigma reduction activities/trainings.



MULTI-TIERED SYSTEM OF SUPPORT, VCOE

Conclusion and Recommendations

Over the last three school years, MTSS has demonstrated a sustained positive impact by connecting students and families with mental health services, educating school communities, and reducing mental health stigma. Each evaluation highlighted success in expanding mental health awareness and access to care within schools and communities. As the program has grown, ongoing assessments have identified areas for enhancement, refining both evaluation and program delivery.

A key improvement area has been evaluation methodology. In 2021-2022, post-training survey responses revealed a need for clearer questions, particularly for respondents new to implementing these strategies. Recommendations included making surveys more accessible and aligning tracking logs with PEI regulations. In 2022-2023, the focus shifted to simplifying surveys and data collection to address low response rates in some districts, with suggestions to shorten surveys and ease completion requirements. Implementing these changes in 2023-2024 led to higher survey participation and streamlined data tracking.

MTSS has made programmatic enhancements as well. The 2021-2022 report included recommendations that focused on expanding popular group activities and improving coordination with existing on-campus services, such as Wellness Centers, to streamline student referrals. Expanding accessibility by offering both in-person and digital training options was also advised. The 2022-2023 report recommended exploring alternatives to traditional family engagement formats, such as newsletters and Q&A sessions, to reach a wider audience. A notable addition in 2022 was the focus on embedding wellness access during school hours, with recommendations for scheduling adjustments to allow students to engage with wellness resources without missing key class time. The 2023-2024 recommended expanding successful program aspects and resources to improve engagement and support. Attendees expressed a desire for extended breakout sessions with a variety of structured topics, promoting deeper and more varied discussions among participants. Participants noted an emerging need for additional support with managing challenging student behaviors, including support sessions or resources for educators. Staffing and space utilization at Wellness Centers emerged as a central theme, with recommendations to address these logistical aspects to better serve students.

From 2021-2024, MTSS has made practical and strategic improvements, leading to more effective mental health support for students and families. Regular recommendations to refine evaluation tools, boost engagement, and integrate on-campus services reflect a commitment to building a holistic and accessible program. As of 2023, the focus has shifted from logistical challenges to actively expanding successful elements, ensuring MTSS continues to adapt to the needs of its community.

VENTURA COUNTY BEHAVIORAL HEALTH
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NETWORK EXPANSION GRANTS PROGRAM PREVENTION PROGRAMS

The Network Expansion Grants Programs (NEGP) are time-limited, community-based projects or programs promoting wellness among Ventura County residents. NEGP activities were held between May 2023 and June 2024. The long-term goal of the NEGP is to cultivate unconventional, community-based wellness strategies in Ventura County (see Appendix C for an overview of the impact of NEGP funding on participating organizations and their local communities). Prevention NEGPs used non-traditional approaches to minimize the risk of serious mental illness and strengthen protective factors for the well-being of un- and underrepresented populations.

Program Criteria

New projects/programs supporting underserved populations or regions with prevalent health disparities

Application of new, peer-based approaches to community wellness including:

1) Meaningful input from community members in project/program development.
2) Promotion of individual empowerment, resiliency, and self-determination for participants

Program Highlights

12 prevention grants awarded (and 1 incomplete)

256 individuals engaged in program activities

NETWORK EXPANSION GRANTS PROGRAM PREVENTION PROGRAMS

Overview of NEGP Grantees

Twelve NEGPs provided services to reduce risks and enhance resilience against mental illness, one in FY 2022-2023 and 11 in FY 2023-2024. One NEGP grant was incomplete. Below is a summary of each NEGP prevention grantee.

Amplify Arts Project Girls Rock SB hosted girls and gender-expansive youth in grades 6th to 12th for a weekend centered around exploring their identities, interests, and well-being through music, creative arts, and mentorship. Through various artistic workshops and wellness activities, youth cultivated technical art skills, connections with peers, empathy, and self-discovery.

Autism Society Ventura County held a bi-monthly book club and writing workshop for disabled and neurodivergent adults, families, and caretakers. The workshop enabled participants to tell their stories in their own words and discuss literature related to disability. Program participants developed a sense of community, improved confidence and mental health, and were exposed to literature centering authors and characters reflective of themselves.

Big Brothers Big Sisters of Ventura County's "Team: Changing Minds VC" program expanded professional case management services to gaming and social media environments for youth aged 12 to 17 years who identified as Black, Indigenous, or People of Color (BIPOC) and were struggling with mental health needs. Their case managers and volunteer mentors engaged youth through networked gaming such as Minecraft or Words with Friends in at least 50% of their interactions. This innovative approach to support networks led to improved communication, including disclosing different topics and new adversities and stronger bonds with agency professionals and mentors.

Boys & Girls Club of Greater Oxnard & Port Hueneme engaged underserved youths aged 6-18 in the Be Kind Program. Some workshop topics were on developing the value, impact and importance of kindness; understanding respect, empathy, and consideration; developing strategies to understand their thoughts and emotions; and understanding the power of being present in the moment. Participants received materials to continue these practices and build upon learned skills, as well as resources and linkages for mental health wellness.

Childhood Matters established child-centered, safe spaces in the Ventura County Courthouse equipped with tools and materials to help all children, especially those who were victims of domestic abuse, manage their emotions, self-regulate, and build coping skills. These spaces allowed children to rest and shifted their focus from the experiences that brought them to the courthouse. Adults, including courthouse staff, parents or guardians, were also offered resources for learning how to ensure children have the skills needed to manage their behavior and trauma effectively.

De Colores Multicultural Folk Arts, Inc. engaged older adults and youth, often grandparents and their grandchildren, in intergenerational multimedia art classes over 10 weeks to foster confidence, social connections, and community well-being. At a community reception, program participants showcased their completed projects, ranging from paintings to sculptures.

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NETWORK EXPANSION GRANTS PROGRAM PREVENTION PROGRAMS

NAMBA Rock and Roll High provided a space for creative expression to students aged 12-18 in underserved areas of Ventura through a one-week intensive, high-quality music education course. Students learned musical instruments, vocals, songwriting, and more before performing their original songs live at the end of the program.

No Limits for Deaf Children and Families Community Careers provided knowledge, skills, and inspiration to deaf youth and their siblings through career exploration via hands-on curriculum and field trips. Youth were empowered to broaden their career horizons and confidently pursue any desired profession. Additionally, the program raised awareness about effective communication strategies with deaf individuals, fostering a more inclusive and informed community.

Nyeland Promise sought to reduce stress, anxiety, and depression for Latina women farm workers in Nyeland Acres by providing yoga, educational workshops, art classes and music. Program participants were able to engage in new experiences, like going to a movie theater and developing friendships with community peers. All participants reported feeling less lonely, depressed, and tense after partaking in the different activities offered.

The Elite Theatre Company supported marginalized youth and young adults aged 15-25 to participate in theatre classes and staged productions in The Conservatory Project. The series also included mental health wellness classes covering different mental health topics. The provider used a mental health professional to train the teachers and mentors on mental health-related issues to develop the mental health wellness classes. The project focused on building individual empowerment, resiliency, and self-determination, as well as cultivating the development of transferable life skills and building strong interpersonal connections.

Two Trees Community implemented a prevention program, Paloma Youth, to help Latinas/Latinos ages 9-15 cope with suicidal ideation and prevent self-harm. The program consisted of support groups where youth could talk about problems among peers of similar backgrounds and focus on mindfulness practices, emotion regulation, interpersonal skills, and distress tolerance skills. Group therapy was based on Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT). CBT focuses on how thoughts and behaviors influence each other and is beneficial for anxiety and obsessive-compulsive disorders. DBT focuses on mindfulness practice and emotion regulation and is helpful for suicidal ideation and self-harm.

Ventura County Clergy and Laity United for Economic Justice (CLUE-VC) engaged 37 organizations to host a mental health and family wellness-focused resource fair, "Swap Meet Justice," at Oxnard College, reaching approximately 600 Hispanic/Latinos, immigrants, farm worker families, and monolingual Spanish- and Mixteco-speakers. Five workshops were also offered to participants covering topics like stress relief, early signs of mental illness, diabetes prevention, and first aid.

Santa Paula Town Hall Adelante Project (grant incomplete) would have implemented the El Joven Noble program, which is a comprehensive indigenous-based youth leadership development program

that supports and guides youths through the rights of passage process and focuses on the prevention of substance abuse, teen pregnancy, relationship violence, gang violence, and school failure. The program engages participants in activities that impact their character, shape their development, and provides a positive impact through a culturally responsive scope of practice.

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NETWORK EXPANSION GRANTS PROGRAM PREVENTION PROGRAMS

Demographic Data†

The demographic information for individuals who received NEGP prevention services over the past two years is presented below. One NEGP, CLUE-VC, completed its services in FY 2022-2023, while 11 programs concluded in FY 2023-2024.

Demographic Category	FY 22-23	FY 23-24
Race*	**n = 29**	**n = 189**
American Indian/Alaska Native	0%	4%
Asian	0%	4%
Black/African American	0%	6%
Hispanic/Latino	100%	38%
Native Hawaiian, other Pacific Islander	0%	0%
White	0%	35%
More Than One Race	0%	12%
Another Race	0%	3%
Hispanic/Latino Ethnicity	**n = 27**	**n = 100**
Mexican/Mexican American/Chicano	100%	84%
Central American	0%	7%
Puerto Rican	0%	2%
South American	0%	2%
Another Hispanic/Latino ethnicity	0%	5%
Non-Hispanic/Latino Ethnicity	**n = 0**	**n = 37**
Asian Indian/South Asian	0%	11%
European	0%	49%
Eastern European	0%	11%
African	0%	5%
Filipino	0%	5%
Middle Eastern	0%	5%
Another non-Hispanic/Latino ethnicity	0%	14%
Primary Language*	**n = 29**	**n = 215**
English	17%	81%
Spanish	62%	24%
Indigenous	58%	0%
Another Language	0%	5%

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NETWORK EXPANSION GRANTS PROGRAM
PREVENTION PROGRAMS

Demographic Category	FY 22-23	FY 23-24
Age Groups	**n = 28**	**n = 200**
0-15 years	18%	64%
16-25 years	25%	25%
26-45 years	54%	9%
46-59 years	0%	2%
60+ years	1%	3%
Gender Identity	**n = 28**	**n = 195**
Female	68%	61%
Male	32%	26%
Transgender	0%	3%
Genderqueer	0%	4%
Questioning or Unsure	0%	4%
Another Gender Identity	0%	3%
Sex Assigned at Birth	**n = 28**	**n = 191**
Female	68%	72%
Male	32%	28%
Sexual Orientation	**n = 22**	**n = 168**
Heterosexual or Straight	41%	58%
Bisexual	0%	19%
Gay or Lesbian	0%	8%
Queer	0%	4%
Questioning or unsure of sexual orientation	0%	5%
Another sexual orientation	59%	5%
Disability	**n = 10**	**n = 177**
Yes	4%	22%
No	96%	78%
Disability Type*	**n = 0**	**n = 39**
Difficulty seeing	-	28%
Difficulty hearing or having speech understood	-	31%
Another communication disability	-	13%
Learning disability	-	44%
Developmental disability	-	5%
Dementia	-	0%
Another mental disability not related to mental illness	-	13%
Physical/mobility disability	-	18%
Chronic health condition/chronic pain	-	8%
Another disability	-	21%

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Veteran	n = 27	n = 137
Yes	0%	1%
No	100%	99%

*Total may exceed 100% because participants could select multiple response options.
†Demographic data were not collected by Nyeland Promise.

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NETWORK EXPANSION GRANTS PROGRAM PREVENTION PROGRAMS

Program Outcomes

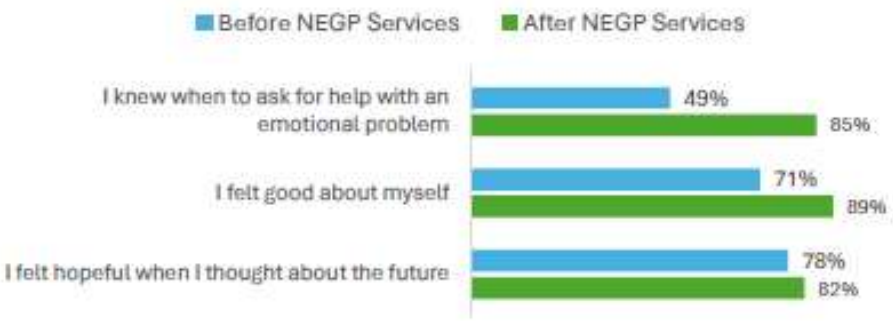
NEGP grantees reported program outcomes, including Two Trees, Amplify Girls Rock Camp, Boys & Girls Clubs of Greater Oxnard and Port Hueneme, De Colores Multicultural Folk Arts, Inc., and Big Brothers Big Sisters of Ventura County. These measures varied based on the nature of services provided and activities organized; however, all respondents were asked to self-assess their knowledge from two perspectives (retrospective pre/post)—before and after receiving services. The survey results from the past two years are presented in the charts below.

Respondents indicated their level of agreement with several statements related to emotional well-being, mental health knowledge, and awareness. The charts below display the number of people who agreed or strongly agreed with each statement. Note that emotional well-being data was not collected in FY 2022-2023.

Before and After: Emotional Awareness†

Percentage of Respondents Who Agree/Strongly Agree for FY 23-24

(n=130-131)



†Two Trees and Amplify Girls Rock Camp collected emotional awareness data.

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NETWORK EXPANSION GRANTS PROGRAM PREVENTION PROGRAMS

Program Outcomes

Mental Health Knowledge & Awareness†

Percentage Respondents Who Agreed Before NEGP Services

Mental Health Knowledge & Awareness†

Percentage of Respondents Who Agreed After NEGP Services

†Mental health knowledge and awareness data were collected by Amplify the Arts, Big Brothers Big Sisters, Boys and Girls Club, De Colores, and Two Trees.

*Items were collected by Big Brothers Big Sisters, Boys and Girls Club, and De Colores.

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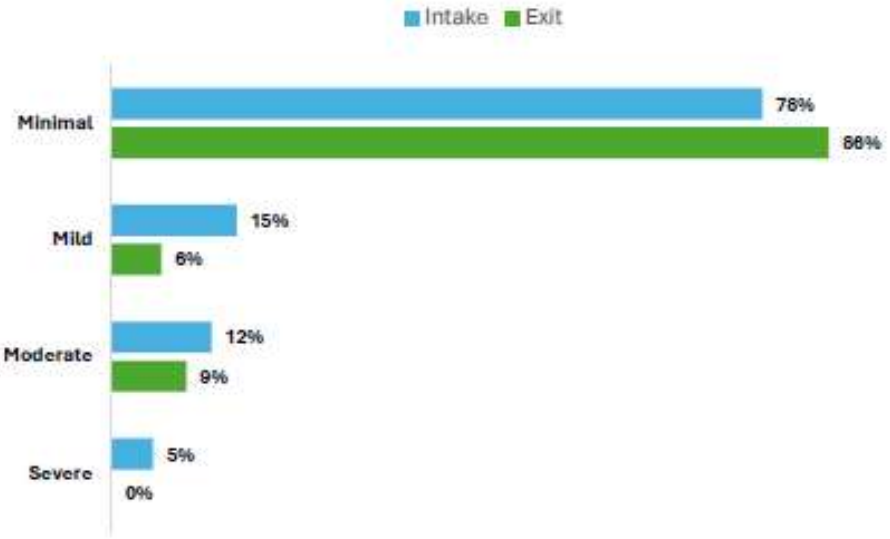
NETWORK EXPANSION GRANTS PROGRAM PREVENTION PROGRAMS

Program Outcomes

NEGPs also assessed respondents' psychological health at two points (intake and exit) using the 10-item Schwartz Outcome Scale (SOS-10) measure. Higher scores on this measure indicate greater psychological well-being/lower levels of distress. Comparisons of intake and exit scores are presented in the chart below.

Categorization of SOS-10 Scores* Before and After NEGP Services for FY 23-24†*

(n1 = 41, n2 = 35)



†SOS-10 data collected by Elite Theatre, NAMBA, and Two Trees.

Average SOS-10 scores went from 43.8 at intake to 48.7 at exit, indicating improved psychological well-being and reduced levels of distress among respondents.

*Total score on the SOS-10 ranges from 0–60 and scores are categorized as minimal (40–60), mild (33–39), moderate (23–32), or severe (0–22) levels of distress.

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NETWORK EXPANSION GRANTS PROGRAM PREVENTION PROGRAMS

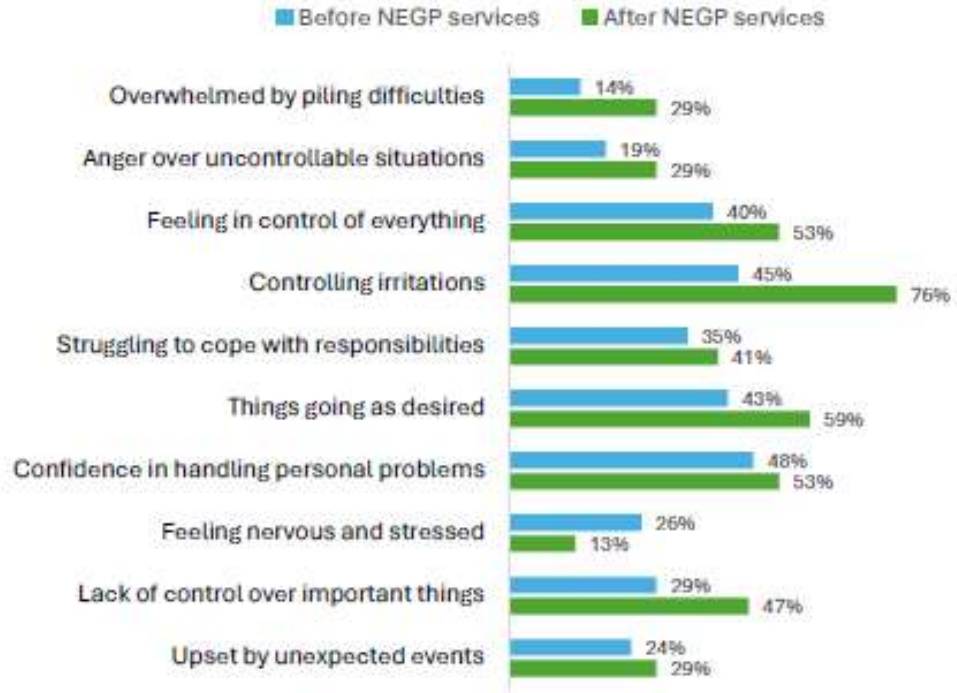
Program Outcomes

NEGP grantee Nyeland Promise asked their respondents to reflect on their perceived stress and coping abilities over the past month, both before and after receiving services. The survey results collected during FY 2023-2024 are presented in the chart.

Perceived Stress and Coping Abilities in the Past Month

Percentage of Respondents Reporting Quite Frequently/Very Often for FY 23-24

(N=16-21)



After NEGP services, participants reported improved emotional regulation, confidence, and control over challenges, though some difficulties with unexpected events and stressful situations remain.

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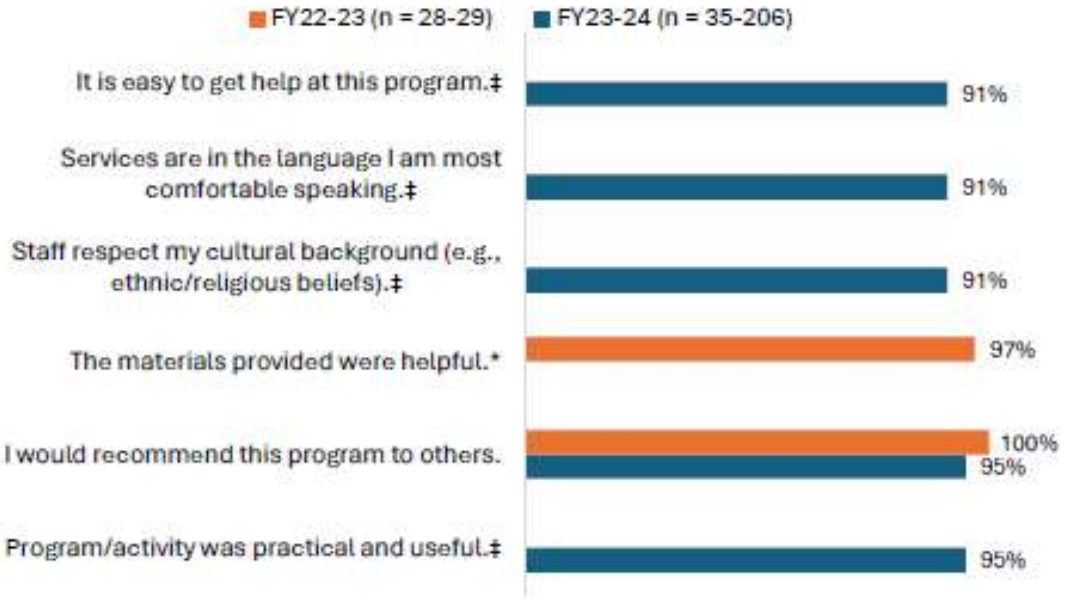
NETWORK EXPANSION GRANTS PROGRAM PREVENTION PROGRAMS

Program Satisfaction

Respondents were asked to rate their level of agreement or disagreement with several statements regarding the program/activity as an indicator of their satisfaction with the NEGP prevention program. The chart below shows the number of respondents who agreed or strongly agreed with each statement over the past two years.

Respondents Feedback on Program Effectiveness†

Percentage of Agree/Strongly Agree Responses for Key Statements



Nearly all respondents expressed complete satisfaction with the NEGP prevention program activities.

†FY 22-23 program satisfaction collected was collected by CLUE-VC. FY 23-24 program satisfaction data was collected by Amplify the Arts, Big Brothers Big Sisters, Boys and Girls Club, De Colores, NAMBA, Elite Theatre, and Two Trees.
*Data not collected in FY 23-24.
‡Data not collected in FY 22-23.

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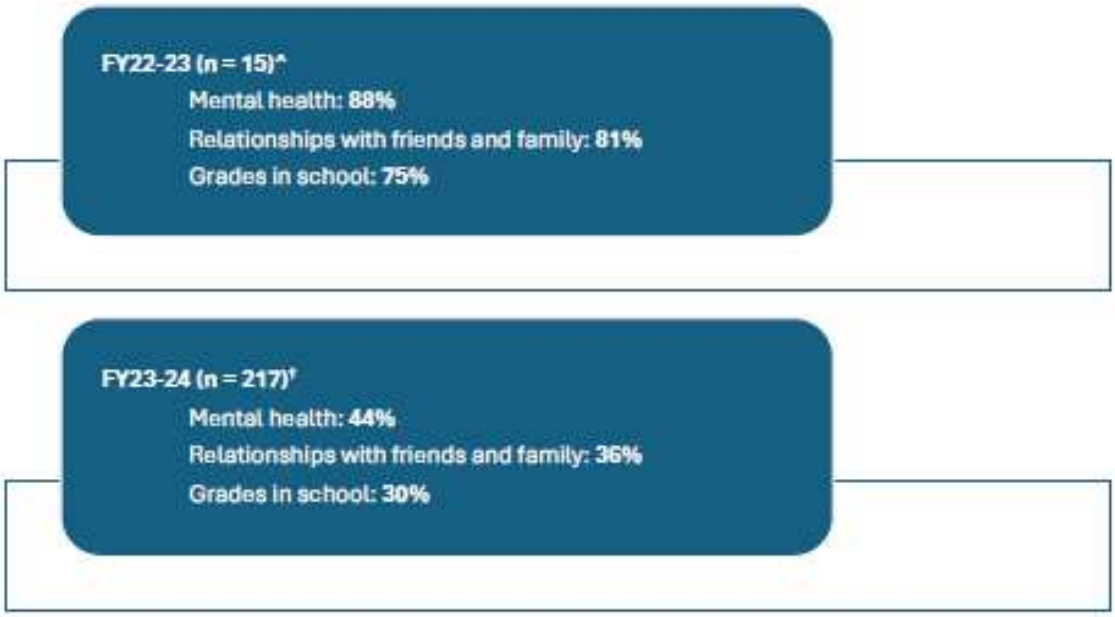
NETWORK EXPANSION GRANTS PROGRAM PREVENTION PROGRAMS

Areas of Support

Respondents were asked to select areas where they needed additional support from a list of nine options. The figure below displays the top Areas of Need and the percentage of respondents who indicated they needed help in each area for the past two years. These insights can guide providers in enhancing services for the upcoming fiscal year.



†FY 23-24 areas of support data were collected by Amplify the Arts, Big Brothers Big Sisters, Boys and Girls Club, De Colores, NAMBA, Elite Theatre, and Two Trees. FY 22-23 areas of support data were collected by CLUE-VC.

NETWORK EXPANSION GRANTS PROGRAM PREVENTION PROGRAMS

Program Feedback

Respondents who received program services from prevention NEGP provided additional feedback through two open-ended response questions. Their comments were categorized into themes for each grantee, and the theme descriptions from the past two years are presented in the table below.

NEGP Grantee	Most Helpful About Program	Program Improvements
FY 23-24		
Amplify Arts Project Girls Rock SB	• Opportunity to meet new people and build friendships. • Inclusive, non-judgmental environment fostering acceptance. • Improved social skills through stepping out of comfort zones.	• Desire for more freedom and personalization • Suggestions for increased independence, such as using phones and selecting activities. • Requests for clearer schedules and more private spaces for older participants.
Big Brothers Big Sisters of Ventura County	• Appreciation for staff expertise and accessibility. • Personal connections with staff enhancing positive experiences. • Importance of friendships and support among peers.	• Importance of avoiding pressure to engage while ensuring no one feels left out. • Desire for flexibility in engagement and options to participate on personal terms.

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NETWORK EXPANSION GRANTS PROGRAM PREVENTION PROGRAMS

NEGP Grantee	Most Helpful About Program	Program Improvements
Boys & Girls Clubs of Greater Oxnard and Port Hueneme	• Gained self-awareness and emotional regulation. • Program addressed personal challenges related to anger and bullying. • Valuable lessons in social responsibility and supporting others.	• Suggestions for more community outreach, events, and field trips. • Belief that additional resources, donations, and funding would enhance the experience. • Desire for increased enthusiasm and engagement from participants
De Colores Multicultural Folk Arts, Inc	• Educational and creative components valued by participants. • Opportunities to learn new skills like art and sketching. • Creative activities served as therapeutic outlets and facilitated beneficial interactions.	• Positive reflections on the program, focusing on instruction quality and learning opportunities. • Desire for more time to engage with the material. • Suggestions for improving the classroom environment to enhance learning.
NAMBA Rock & Roll Band Camp	• Importance of a supportive community in the program. • Environment fostered comfort and connections with staff and peers. • Creative atmosphere and learning opportunities, particularly in music, enhanced personal growth.	• Varied opinions on group size; some wanted larger groups, others preferred smaller ones. • Calls for more personalized experiences, like choosing bands or groups. • Desire for increased practice time for activities such as performances.

NETWORK EXPANSION GRANTS PROGRAM PREVENTION PROGRAMS

NEGP Grantee	Most Helpful About Program	Program Improvements
The Elite Theatre Company	• Program provided valuable opportunities for skill development in acting and technical areas. • Participants deepened their understanding of acting techniques using personal emotions. • Emotional support increased self-confidence and fostered a sense of belonging and camaraderie.	• Mixed feedback on program duration; some wanted it longer, others found it too long. • Need for better communication between the production team and participants. • Request for increased funding to support production aspects.
Two Trees Community	• Valued judgment-free environment for open communication and emotional sharing. • Supportive space fostered collaboration and personal growth. • Available resources accommodated individual needs and encouraged creativity.	• Desire to expand the program's reach and improve advertising. • Interest in familiar faces and a more diverse group for engagement. • Request for year-round offerings for continuity.
FY 22-23		
CLUE-VC	• Stress management techniques • Choking/First Aid for children • Diabetes prevention • Mental health information	-

†FY 23-24 program feedback data not collected by Autism Society, Childhood Matters, No Limits Theater, and Nyeland Promise.

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NETWORK EXPANSION GRANTS PROGRAM
PREVENTION PROGRAMS

Conclusions and Recommendations

Prevention NEGPs have successfully engaged a diverse range of community groups, including Hispanic/Latino populations. They primarily focus on youth while also reaching individuals of various ages. Their overall impact has been beneficial, as evidenced by improvements in emotional well-being, mental health awareness, and coping skills, which were reflected in both survey results and qualitative feedback.

Many of the NEGPs created safe and inclusive spaces, allowing participants to express themselves and learn about emotional and mental health without fear of judgment. Additionally, grantees fostered a sense of community by facilitating connections among peers and program staff. Moving forward, it is recommended that Prevention NEGPs continue to prioritize inclusivity and support for diverse populations while enhancing outreach efforts to strengthen community ties further and promote mental health awareness.

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ONE STEP A LA VEZ

One Step a La Vez (OSALV) serves multiple populations including the Latino community in Fillmore, Piru, and Santa Paula, youth and Transitional Age Youth (TAY) ages 13–25, LGBTQ+ youth, youth in the juvenile justice system, and youth and TAY who are homeless or at risk of homelessness. One Step a La Vez offers a drop-in center for mental health resources, wraparound support, youth leadership activities, LGBTQ+ support groups, and classes on topics related to stress, coping, and wellness.

Program Strategies

Improves timely access and linkages to services for underserved populations by reaching youth, TAY, and Latinos who might not otherwise get help.

Implements non-stigmatizing and non-discriminatory practices by providing culturally competent and LGBTQ+-sensitive services, workshops, and presentations.

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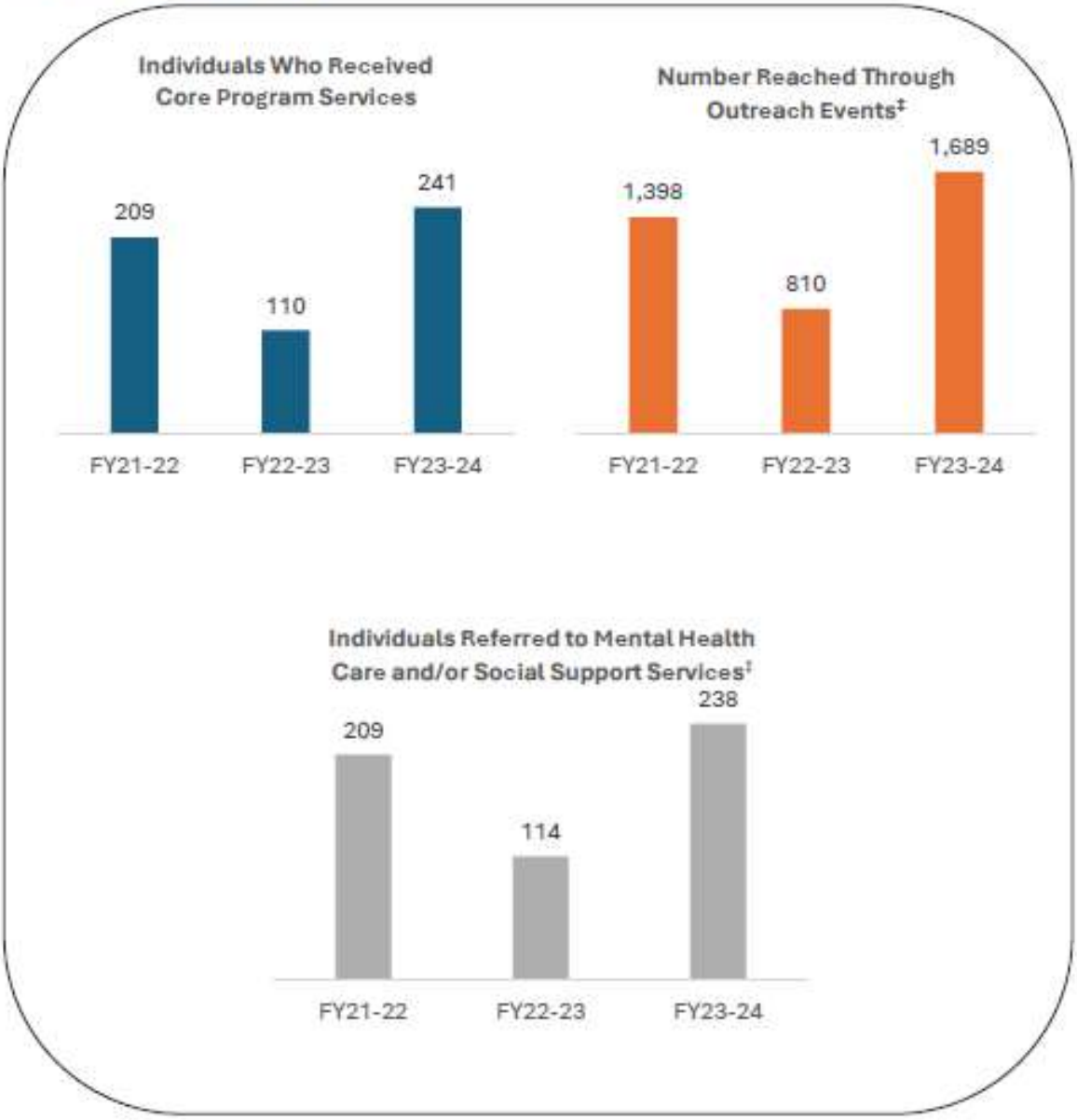
ONE STEP A LA VEZ

Program Highlights‡



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ONE STEP A LA VEZ

Demographic Data

One Step a La Vez collects unduplicated demographic data from the individuals it serves. The data in this section represents information from 421 individuals who completed a demographic form in the past three years.

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Race*	**n = 64**	**n = 105**	**n = 239**
American Indian/Alaska Native	0%	1%	0%
Asian	0%	0%	0%
Black/African American	0%	2%	0%
Hispanic/Latino	95%	92%	100%
Native Hawaiian, other Pacific Islander	2%	0%	0%
White	8%	5%	0%
More Than One Race	8%	0%	0%
Other	2%	0%	0%
Ethnicity*	**n = 62**	**n = 99**	**n = 240**
Hispanic/Latino			
Caribbean	0%	0%	0%
Central American	3%	0%	0%
Mexican/Mex.-Am./Chicano	90%	97%	100%
Puerto Rican	2%	0%	0%
South American	0%	0%	0%
Other Hispanic/Latino	3%	2%	0%
Non-Hispanic/Latino			
African	2%	1%	0%
Asian Indian/South Asian	0%	0%	0%
Cambodian	0%	0%	0%
Chinese	0%	0%	0%
Eastern European	0%	0%	0%
European	0%	0%	0%
Filipino	0%	5%	0%
Japanese	2%	0%	0%
Korean	0%	0%	0%
Middle Eastern	0%	0%	0%
Vietnamese	0%	0%	0%
More than one	3%	0%	0%
Other Non-Hispanic/Latino	0%	0%	0%

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ONE STEP A LA VEZ

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Primary Language*	**n = 68**	**n = 113**	**n = 239**
English	54%	50%	33%
Spanish	51%	49%	83%
Indigenous	0%	0%	0%
Mixteco	-	1%	0%
Age Groups	**n = 67**	**n = 101**	**n = 238**
0-15 years	63%	70%	40%
16-25 years	37%	30%	20%
26-59 years	0%	0%	37%
60+ years	0%	0%	3%
Gender Identity	**n = 66**	**n = 109**	**n = 240**
Male	48%	52%	55%
Female	44%	46%	44%
Transgender	3%	1%	<1%
Genderqueer	0%	0%	0%
Questioning or Unsure	5%	0%	0%
Another Gender Identity	0%	1%	0%
Sex Assigned at Birth	**n = 64**	**n = 100**	**n = 238**
Male	48%	54%	56%
Female	52%	46%	44%
Sex Sexual Orientation	**n = 60**	**n = 97**	**n = 238**
Heterosexual or Straight	85%	86%	99%
Gay/Lesbian	0%	0%	1%
Bisexual	6%	8%	0%
Queer	2%	3%	0%
Questioning/Unsure	2%	2%	0%
Another sexual orientation	5%	1%	0%
Disability	**n = 65**	**n = 101**	**n = 240**
Yes	8%	9%	0%
No	92%	91%	100%

ONE STEP A LA VEZ

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Disability Type*	**n = 5^**	**n = 7^**	**n/a**
Chronic Health Condition/Chronic pain	0%	0%	-
Dementia	0%	0%	-
Developmental disability	40%	0%	-
Difficulty Hearing, or having speech understood	20%	0%	-
Difficulty Seeing	60%	71%	-
Another Communication Disability	40%	0%	-
Learning Disability	80%	0%	-
Mental Disability	0%	0%	-
Physical/Mobility Disability	0%	0%	-
Another Mental Disability	0%	14%	-
Another Disability	0%	14%	-
Veteran	**n = 65**	**n = 107**	**n = 240**
Yes	0%	0%	0%
No	100%	100%	100%

*Total may exceed 100% because participants could choose multiple response options.

^ Small sample sizes can make results less reliable and more affected by unusual values, so these findings should be interpreted cautiously.

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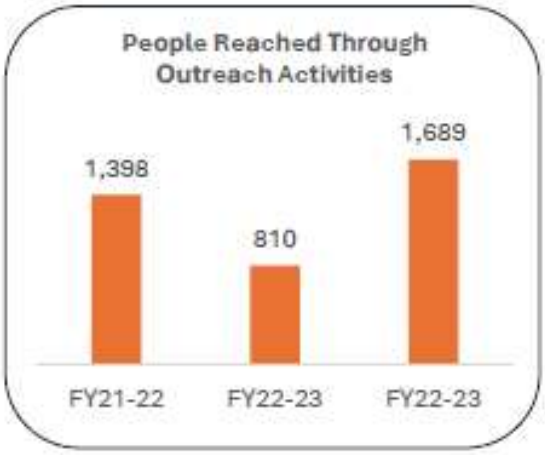
ONE STEP A LA VEZ

Program Activities & Outreach

Program activities include classes, meetings, support groups, trainings, and workshops One Step a La Vez program staff facilitated. Program participants and other community members may participate in these activities and events.

Activity Type	FY 21-22	FY 22-23	FY 23-24
One Step Center	-	90	-
Food Distribution	25	12	41
Class	92	80	-
Support Group	44	10	27
Meeting	37	4	76
Training Workshop	-	2	23
Drop-in Program	29	1	-
Community Service	-	-	12
Family Dinner	-	-	38
Field Trip	-	4	18
Other	15	2	27
Total Activities	**242**	**205**	**263**

Program Outreach Type	FY 21-22	FY 22-23	FY 23-24
Outreach/Outreach Misc.	17	1	16
Meeting or Interagency Meeting	16	19	22
Other	4	-	-
Total Outreach Activities	**37**	**20**	**38**



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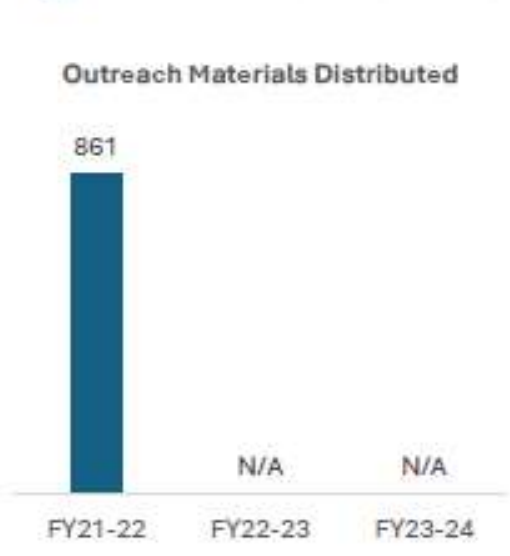
ONE STEP A LA VEZ

Program Activities & Outreach (continued)



From FY21-22 to FY23-24:

The number of participants in program activities increased by 98%

The percentage of activities and events offered in Spanish increased by 35% activities and 46% outreach events

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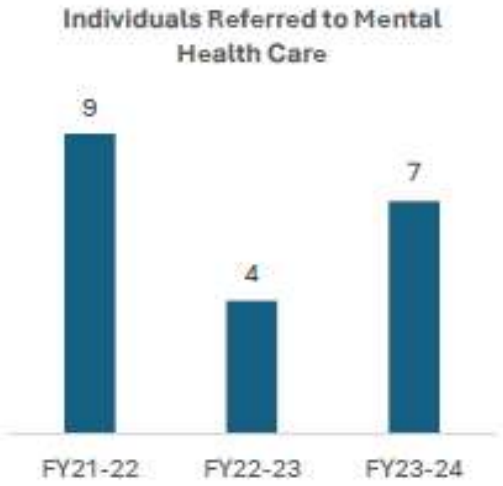
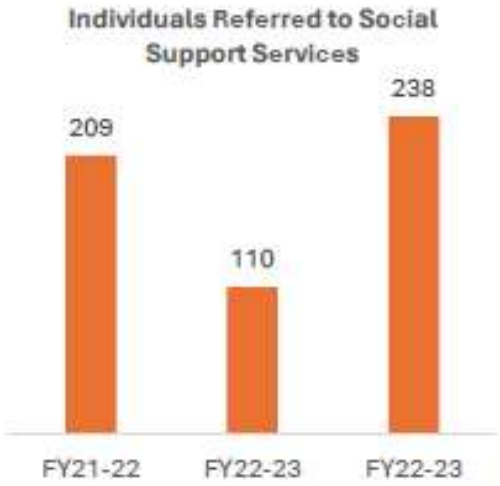
ONE STEP A LA VEZ

Program Referrals

Program referrals include mental health care referrals to VCBH or other MHSA prevention, early intervention, or treatment programs. One Step a La Vez also makes referrals to social supports such as food, housing, health insurance, and other support services.





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ONE STEP A LA VEZ

Program Outcomes

One Step a La Vez tracks outcomes for program participants (e.g., individuals who attend the drop-in center) using the Schwartz Outcome Scale (SOS-10), a 10-item measure of psychological health. Higher scores on this measure indicate greater psychological well-being and lower levels of distress. The chart below compares intake and exit scores.

Schwartz Outcome Scale (SOS-10)*		FY 21-22 Intake = 0, Exit =27	FY 22-23 Intake = 28, Exit =16	FY 23-24 Intake = 99, Exit = 12
Minimal	Intake	-	64%	95%
	Exit	78%	88%	100%
Mild	Intake	-	18%	4%
	Exit	15%	6%	0%
Moderate	Intake	-	11%	0%
	Exit	3%	0%	0%
Severe	Intake	-	7%	1%
	Exit	4%	6%	0%

Each year:

Each year, participants reported minimal levels of distress, on average: 80% at Intake, and 89% at Exit

*Total score on the SOS-10 ranges from 0–60 and scores are categorized as minimal (40–59), mild (33–39), moderate (23–32), or severe (1–22) levels of distress.

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ONE STEP A LA VEZ

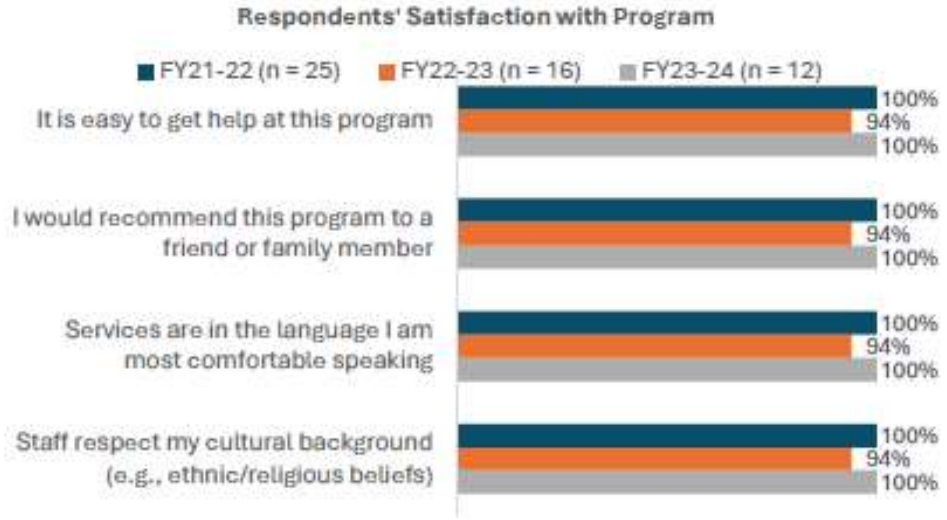
Program Outcomes

One Step a La Vez collected additional outcomes related to knowledge during FY23-24. The chart below displays these results.

ONE STEP A LA VEZ

Program Satisfaction

To measure their satisfaction with OSALV, participants were asked to indicate the extent to which they disagreed or agreed with several statements about the program. The percentage of participants who agreed or strongly agreed with each statement is shown in the chart below.



In FY23-24, additional items were included to measure training satisfaction. The percentage of participants who agreed or strongly agreed with each statement is shown in the chart below.

Virtually all participants were *completely satisfied* with OSALV's program and staff.

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ONE STEP A LA VEZ

Areas of Support

Participants were asked to select areas where they needed additional support from a provided list of options. The chart below highlights the top support areas identified over the past three years. These insights can guide providers in enhancing services for the upcoming fiscal year.

FY21-22 (n = 27)
- Grades in school: **67%**
- Relationships with friends and family: **22%**
- Mental health: **19%**

FY22-23 (n = 16)
- Grades in school: **69%**
- School attendance: **50%**
- Relationships with friends and family: **31%**

FY23-24 (n = 150)
- School attendance: **53%**
- Grades in school: **33%**
- Relationships with friends and family: **27%**

*Total percentage may exceed number of participants because they could choose more than one response option.

ONE STEP A LA VEZ

Conclusions and Recommendations

Over the past three-year evaluation period, OSALV data shows consistent, wide-reaching engagement across core services, outreach events, and program activities, directly serving 560 individuals and reaching over 3,897 through outreach efforts. Additionally, services increasingly targeted Spanish-speaking communities, enhancing accessibility and relevance to diverse populations. Referrals to mental health and social support services were maintained consistently, aligning with program goals of addressing mental health needs and providing access to social support.

While variations are present across the three fiscal years, the program consistently improved psychological well-being and reduced participant distress levels. FY 23-24 shows a high proportion of participants in the "minimal" distress category at intake and exit, reflecting the program's effectiveness in supporting mental health stability. Additionally, participants reported increased confidence in their mental health awareness and self-efficacy. Nearly all respondents expressed confidence in knowing when to seek help, where to go for mental health services, and feeling hopeful and positive about their future, suggesting that the program successfully enhances mental health literacy and optimism.

Participant satisfaction was consistently high across all fiscal years, with positive responses to questions about cultural respect, language accessibility, and overall program recommendation reaching 100% in the most recent year. Respondents also valued training materials and found the courses practical, with nearly all participants indicating they would recommend the training to others. The data suggests that the program meets participants' needs effectively and builds a supportive, culturally sensitive environment. Enhancing targeted support in school-related areas and family relationships may further benefit participants, particularly as these areas have shown varying engagement levels over the years.

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PROGRAM TO ENCOURAGE ACTIVE, REWARDING LIVES FOR SENIORS (PEARLS)
County of Ventura Human Service Agency Area on Aging (HSA)

Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) is an evidence-based case management program for seniors that teaches participants the necessary skills to move forward and make positive changes. PEARLS provides eight sessions over 12 weeks, covering three behavioral approaches to depression management: (1) teaches participants to recognize symptoms of depression and understand the link between unsolved problems and depression, (2) helps participants meet recommended levels of social and physical activity, and (3) helps participants identify and participate in personally pleasurable activities. In addition to the sessions and follow-up phone calls, PEARLS makes assessments to ensure that other potential factors contributing to depression, such as chronic medical conditions, are adequately treated.

Program Strategies

Provides access and linkage to services for older adults by conducting outreach.

Improves timely access to services for underserved populations (older adults) who might not otherwise get help.

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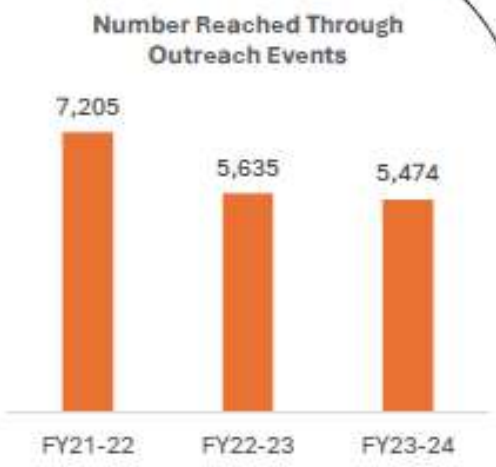
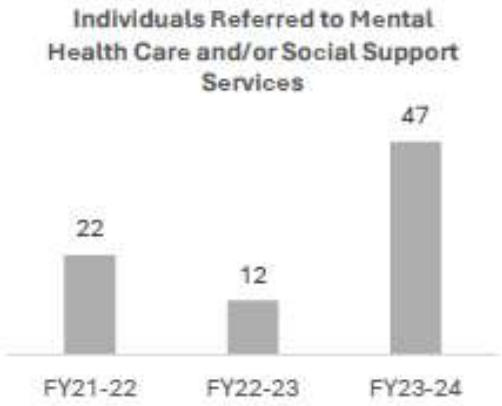
PROGRAM TO ENCOURAGE ACTIVE, REWARDING LIVES FOR SENIORS

Program Highlights[†]





[†]Number of individuals may be duplicated.

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PROGRAM TO ENCOURAGE ACTIVE, REWARDING LIVES FOR SENIORS

Demographic Data

HSA collects unduplicated demographic data from the individuals they serve. Data in this section represents demographic information provided by 649 individuals served in the PEARLS program over the past three years.

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Race*	**n = 225**	**n = 172**	**n = 215**
American Indian/Alaska Native	3%	1%	1%
Asian	1%	2%	3%
Black/African American	4%	3%	4%
Hispanic/Latino	32%	30%	30%
Native Hawaiian/Other Pacific Islander	1%	0%	0%
White	61%	63%	61%
More Than One Race	0%	0%	0%
Other	1%	0%	0%
Ethnicity*	**n = 139**	**n = 55**	**n = 120**
Hispanic/Latino			
Caribbean	0%	0%	1%
Central American	2%	0%	1%
Mexican/Mex.-Am./Chicano	42%	48%	49%
Puerto Rican	0%	4%	0%
South American	4%	6%	4%
Other Hispanic/Latino	1%	0%	1%
Non-Hispanic/Latino			
African	2%	0%	2%
Asian Indian/South Asian	1%	0%	2%
Cambodian	0%	0%	0%
Chinese	0%	0%	0%
Eastern European	6%	4%	3%
European	38%	35%	33%
Filipino	2%	0%	3%
Japanese	1%	1%	0%
Korean	0%	0%	0%
Middle Eastern	1%	1%	3%
Vietnamese	0%	0%	0%
More than one	0%	0%	2%
Other Non-Hispanic/Latino	4%	1%	0%

VENTURA COUNTY
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PROGRAM TO ENCOURAGE ACTIVE, REWARDING LIVES FOR SENIORS

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Primary Language	**n = 240**	**n = 184**	**n = 225**
English	80%	78%	80%
Spanish	19%	20%	20%
Other	1%	2%	1%
Age Groups	**n = 240**	**n = 183**	**n = 224**
0-15 years	0%	0%	0%
16-25 years	0%	0%	0%
26-59 years	10%	8%	3%
60+ years	90%	92%	97%
Gender Identity*	**n = 238**	**n = 181**	**n = 225**
Male	16%	20%	20%
Female	84%	80%	80%
Transgender	0%	0%	<1%
Genderqueer	0%	0%	0%
Questioning or Unsure	0%	0%	0%
Another Gender Identity	0%	0%	0%
Sex Assigned at Birth	**n = 237**	**n = 175**	**n = 225**
Male	16%	20%	20%
Female	84%	80%	80%
Sexual Orientation	**n = 225**	**n = 168**	**n = 190**
Heterosexual or Straight	99%	99%	99%
Bisexual	0%	0%	<1%
Gay or Lesbian	1%	1%	<1%
Queer	0%	0%	0%
Questioning or Unsure	0%	0%	0%
Another Sexual Orientation	0%	0%	0%
Disability	**n = 234**	**n = 178**	**n = 222**
Yes	71%	71%	80%
No	29%	29%	20%

VENTURA COUNTY
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A Department of Ventura County Health Care Agency

PROGRAM TO ENCOURAGE ACTIVE, REWARDING LIVES FOR SENIORS

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Disability Type*	**n = 165**	**n = 127**	**n = 177**
Chronic Health Condition/Chronic Pain	47%	50%	54%
Dementia	2%	2%	2%
Developmental Disability	0%	0%	0%
Difficulty Hearing, or having speech understood	11%	18%	20%
Difficulty Seeing	21%	35%	42%
Learning Disability	2%	2%	2%
Mental Disability	2%	-	-
Physical/Mobility Disability	58%	65%	64%
Another Mental Disability	0%	2%	3%
Another Communication Disability	-	-	1%
Another Disability	96%	42%	36%
Veteran Status	**n = 238**	**n = 179**	**n = 225**
Yes	6%	6%	7%
No	94%	94%	93%

*Total may exceed 100% because participants could choose multiple response options.

* Data not collected.

VENTURA COUNTY BEHAVIORAL HEALTH
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PROGRAM TO ENCOURAGE ACTIVE, REWARDING LIVES FOR SENIORS

Program Activities & Outreach

Program activities include PEARLS counseling by HSA program staff. Program outreach includes activities to promote PEARLS in the community, increase mental health awareness, and link community members to mental health resources.

Activity Type	FY 21-22	FY 22-23	FY 23-24
PEARLS Counseling Sessions	245	186	225
Total Activities	**245**	**186**	**225**

Program Outreach Type	FY 21-22	FY 22-23	FY 23-24
Community Fair or Event	1	1	0
Meeting	2	0	0
Presentation	6	0	4
Personal/Individual	15	0	0
Outreach/Outreach Misc.	5	7	0
Other	2	16	21
Total Outreach Activities	**31**	**24**	**25**

VENTURA COUNTY BEHAVIORAL HEALTH
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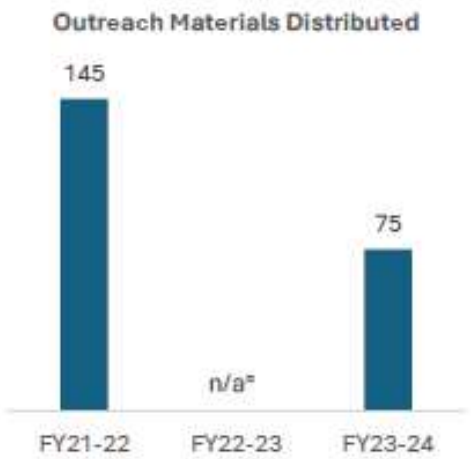
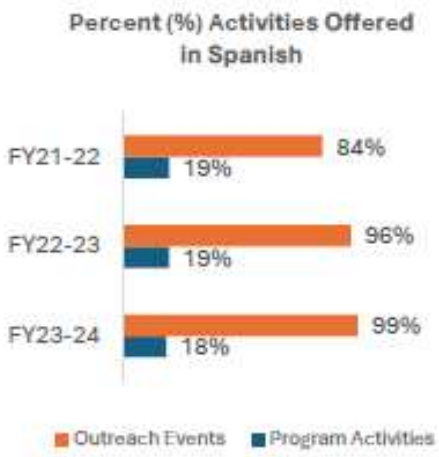
PROGRAM TO ENCOURAGE ACTIVE, REWARDING LIVES FOR SENIORS

Program Activities & Outreach (continued)





From FY21-22 to FY23-24:

The number of participants in program activities increased by 21% in the past fiscal year†

The percentage of activities and events offered in Spanish has been consistently ensured across all offerings

†Number of people reached may be duplicated because individuals could attend multiple activities/events.
*Outreach materials were distributed; but the quantities were not tracked.

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PROGRAM TO ENCOURAGE ACTIVE, REWARDING LIVES FOR SENIORS

Program Outcomes

PEARLS/HAS tracks program outcomes by asking participants to self-assess their knowledge from two perspectives (intake and exit) using the Schwartz Outcome Scale (SOS-10), a 10-item measure of psychological health. Higher scores on this measure indicate greater psychological well-being/lower levels of distress. Survey results for the past three years are presented in the chart below.

Schwartz Outcome Scale (SOS-10)		FY 21-22 Intake = 45, Exit =18	FY 22-23 Intake = 25, Exit =10	FY 23-24 Intake = 82, Exit = 63
Minimal	Intake	31%	40%	35%
	Exit	50%	40%	57%
Mild	Intake	27%	16%	11%
	Exit	28%	40%	13%
Moderate	Intake	22%	24%	27%
	Exit	17%	10%	14%
Severe	Intake	20%	20%	27%
	Exit	5%	10%	16%

Each year:

Each year, participants reported minimal levels of distress, on average:
35% at Intake
49% at Exit

*Total score on the SOS-10 ranges from 0–60 and scores are categorized as minimal (40–59), mild (33–39), moderate (23–32), or severe (1–22) levels of distress.

VENTURA COUNTY BEHAVIORAL HEALTH
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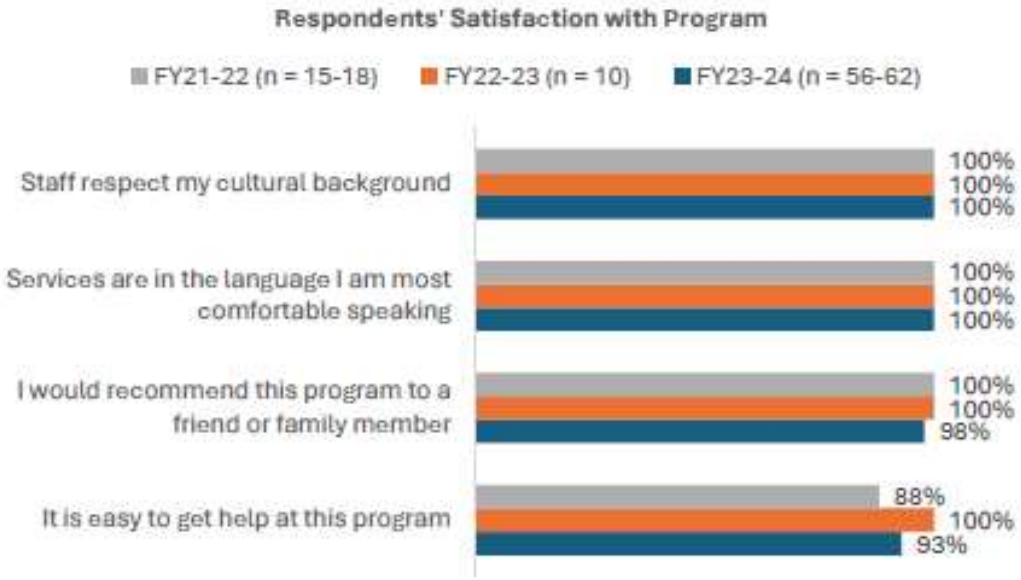
PROGRAM TO ENCOURAGE ACTIVE, REWARDING LIVES FOR SENIORS

Program Satisfaction

Participants were asked to indicate the extent to which they agreed or disagreed with several statements about the program as a measure of their satisfaction with PEARLS/HSA program and services. The chart below shows the percentage of participants who strongly agreed or agreed with each statement.



Most participants were highly satisfied with PEARLS/HSA's program and staff.

VENTURA COUNTY
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PROGRAM TO ENCOURAGE ACTIVE, REWARDING LIVES FOR SENIORS

Areas of Support

Participants were asked to select areas where they needed additional support from a list of options. The chart below highlights the top support areas identified over the past three years.

FY21-22 (n = 18)
- Mental health: **72%**
- Relationships with friends and family: **56%**
- Housing: **28%**

FY22-23 (n = 10)
- Mental health: **90%**
- Relationships with friends and family: **70%**
- Housing: **30%**

FY23-24 (n = 57)
- Mental health: **79%**
- Relationships with friends and family: **65%**
- Housing situation: **26%**

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY
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PROGRAM TO ENCOURAGE ACTIVE, REWARDING LIVES FOR SENIORS

Program Feedback

Participants in PEARLS/HSA services were asked to provide additional feedback through two open-ended questions. Their comments were categorized by theme, with the most common responses highlighted. Given that the program has evolved over the past three years, and staff has actively addressed previous challenges, only feedback specific to the fiscal year 2023-2024 is included in the chart below.

What was most helpful about this program?	•Participants found the program most helpful for its emotional support and companionship, which contributed to their increased empowerment and confidence. They also appreciated the practical guidance and support provided (e.g., goal-setting assistance, resources, coping strategies), as well as the program's accessibility and convenience.
What would make this program better?	•Participants frequently wished for the program to be extended, requesting more or longer individual sessions and additional time with their social workers. They also desired continued support after the program's official end, including periodic check-ins through various means to maintain emotional and practical assistance.

*Total percentage may exceed number of participants because they could choose more than one response option.

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PROGRAM TO ENCOURAGE ACTIVE, REWARDING LIVES FOR SENIORS

Conclusions and Recommendations

The Program to Encourage Active, Rewarding Lives for Seniors has effectively supported older adults in managing depression and improving their well-being. Through structured sessions that teach depression management skills, encourage social and physical activity, and promote enjoyable activities, PEARLS has provided participants with valuable emotional support and empowerment. The program consistently reaches a broad audience, especially underserved senior populations, with notable inclusivity across diverse backgrounds. Participant feedback highlights pyf as a source of companionship, practical guidance, and confidence-building, while outcome measures indicate a positive shift in depression severity by the end of the program.

To enhance PEARLS' impact, expanding the program duration and adding more frequent sessions could provide participants with even more support. Participants expressed a desire for extended or additional sessions and follow-up support, such as periodic check-ins after the program ends. Implementing these elements would help maintain the benefits gained during the program and foster a continued sense of support and community.

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PROJECT ESPERANZA

Our Lady of Guadalupe Church

Project Esperanza, held at Our Lady of Guadalupe Church, is a primary community resource that provides education, sports, and cultural preservation in the Santa Paula area. Project Esperanza serves the Hispanic/Latino community and other underserved populations regardless of race, social status, immigration status, or religious and cultural beliefs. Project Esperanza offers free mental health literacy workshops in partnership with local mental health practitioners and advocates, targeting parents of children enrolled in after-school programs. Educational classes explore a variety of topics on mental health each month, including mental health stigma, wellness, technology, mental health, cyberbullying, self-esteem, anxiety, depression, self-injurious behavior, suicide prevention, children's mental health, and women's and men's mental health. All educational activities focus on prevention, knowledge building, and stigma reduction.

Program Strategies

Improves timely access and linkages to services for underserved populations, including the Hispanic/Latino population, who might not otherwise get help.

Implements non-stigmatizing and non-discriminatory practices by providing culturally competent services, workshops, and presentations.

VENTURA COUNTY BEHAVIORAL HEALTH
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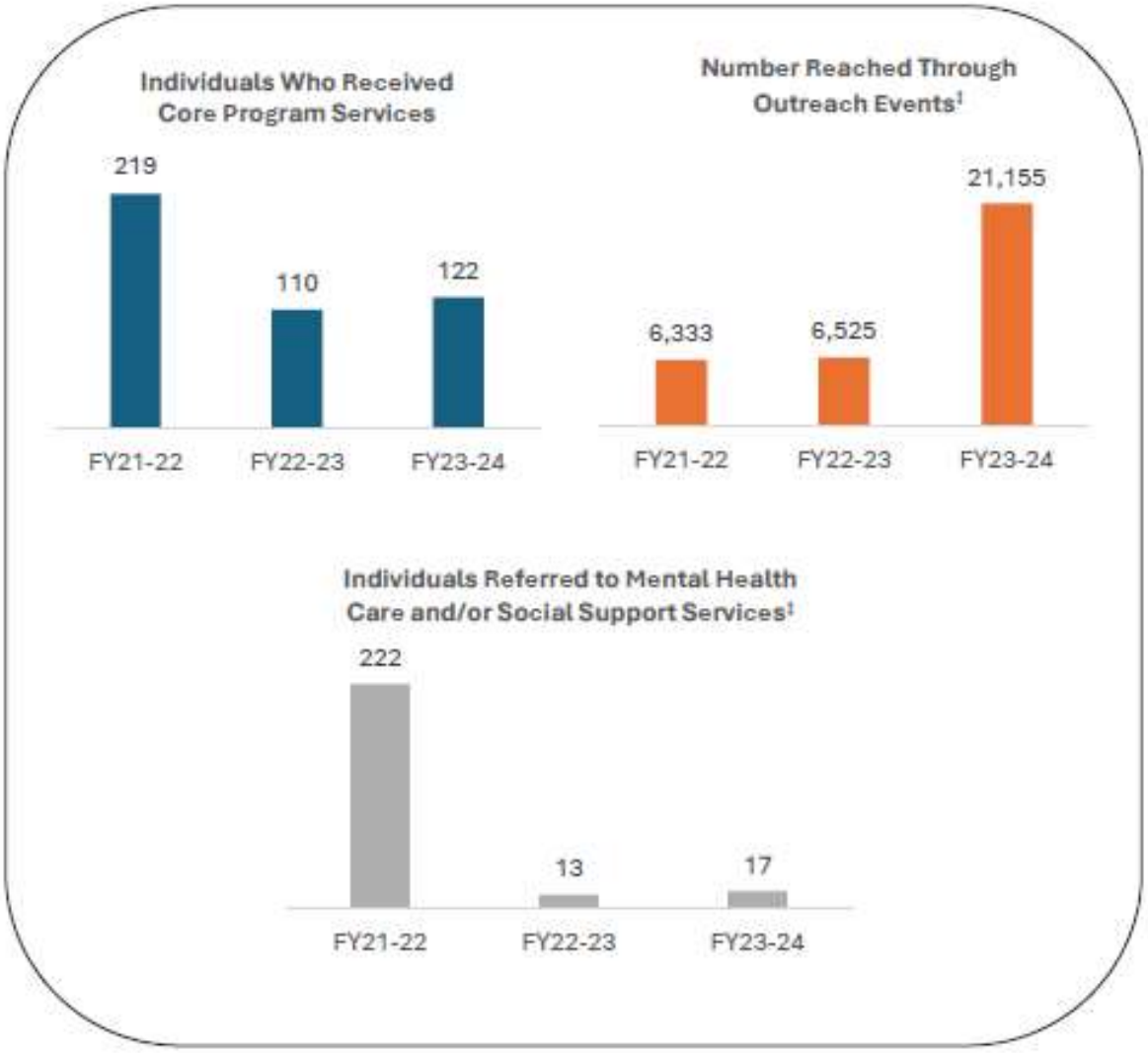
PROJECT ESPERANZA

Program Highlights



[1]Number of individuals may be duplicated

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PROJECT ESPERANZA

Demographic Data

Project Esperanza collects unduplicated demographic data from the individuals it serves. This section presents information from 451 individuals who completed a demographic form over the past three years.

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Race*	**n = 219**	**n = 110**	**n = 122**
American Indian/Alaska Native	0%	0%	0%
Asian	0%	0%	0%
Black/African American	0%	0%	0%
Hispanic/Latino	100%	100%	100%
Native Hawaiian, other Pacific Islander	0%	0%	0%
White	0%	0%	0%
More Than One Race	0%	0%	0%
Other	0%	0%	0%
Ethnicity*	**n = 219**	**n = 110**	**n = 122**
Hispanic/Latino			
Caribbean	0%	0%	0%
Central American	0%	0%	0%
Mexican/Mex.-Am./Chicano	100%	100%	100%
Puerto Rican	0%	0%	0%
South American	0%	0%	0%
Other Hispanic/Latino	0%	0%	6%
Non-Hispanic/Latino			
African	0%	0%	0%
Asian Indian/South Asian	0%	0%	0%
Cambodian	0%	0%	0%
Chinese	0%	0%	0%
Eastern European	0%	0%	0%
European	0%	0%	0%
Filipino	0%	0%	0%
Japanese	0%	0%	0%
Korean	0%	0%	0%
Middle Eastern	0%	0%	0%
Vietnamese	0%	0%	0%
More than one	0%	0%	0%
Other Non-Hispanic/Latino	0%	0%	0%

VENTURA COUNTY BEHAVIORAL HEALTH
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PROJECT ESPERANZA

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Primary Language	**n = 219**	**n = 110**	**n = 122**
English	11%	0%	2%
Spanish	89%	100%	98%
Indigenous	0%	0%	0%
Other	0%	0%	0%
Age Groups	**n = 219**	**n = 109**	**n = 122**
0-15 years	93%	79%	78%
16-25 years	3%	5%	13%
26-59 years	3%	17%	9%
60+ years	1%	1%	0%
Gender Identity	**n = 7***	**n/a¤**	**n/a¤**
Male	0%	-	-
Female	100%	-	-
Transgender	0%	-	-
Genderqueer	0%	-	-
Questioning or Unsure	0%	-	-
Another Gender Identity	0%	-	-
Sex Assigned at Birth	**n = 9***	**n = 55**	**n = 122**
Male	11%	36%	37%
Female	89%	62%	63%
Sex Sexual Orientation	**n = 7***	**n = 0¤**	**n/a¤**
Heterosexual or Straight	100%	-	-
Gay or Lesbian	-	-	-
Bisexual	-	-	-
Queer	-	-	-
Questioning or Unsure	-	-	-
Another sexual orientation	-	-	-
Disability	**n = 168**	**n = 110**	**n = 122**
Yes	0%	0%	0%
No	100%	100%	100%
Veteran	**n = 219**	**n = 110**	**n = 122**
Yes	0%	0%	0%
No	100%	100%	100%

*Total may exceed 100% because participants could choose multiple response options.
ˆ Small sample sizes can make results less reliable and more affected by unusual values, so these findings should be viewed carefully
¤ Data not collected for that Fiscal Year

VENTURA COUNTY BEHAVIORAL HEALTH
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PROJECT ESPERANZA

Program Activities & Outreach

Program activities include classes, meetings, support groups, trainings, and workshops facilitated by Project Esperanza program staff. Program participants and other community members may participate in these activities and events.

Activity Type	FY 21-22	FY 22-23	FY 23-24
Class	228	230	265
Training Workshop	-	18	-
Total Activities	**228**	**248**	**265**

Program Outreach Type	FY 21-22	FY 22-23	FY 23-24
Outreach/Outreach Misc.	5	10	5
Meeting or Interagency Meeting	1	2	1
Presentation	-	4	-
Electronic/Online	-	1	-
Workshop	1	1	1
Community Fair or Event	3	1	4
Faith-Based	-	-	7
Other	2	1	23
Total Outreach Activities	**12**	**20**	**41**

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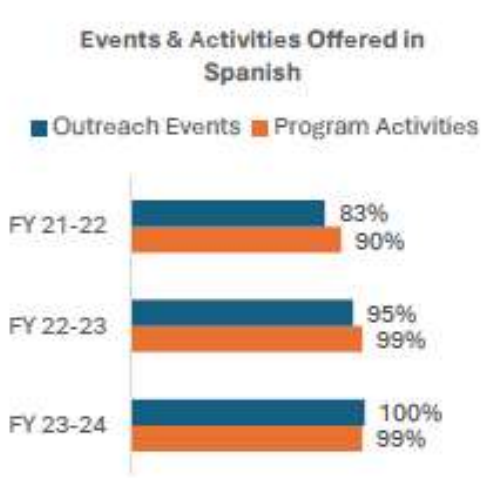
PROJECT ESPERANZA

Program Activities & Outreach (continued)



From FY21-22 to FY23-24:

- The number of participants in program activities increased by 50%
- The number of outreach materials distributed increased by 462%
- The percentage of activities and events offered in Spanish increased by 5% for outreach events

VENTURA COUNTY BEHAVIORAL HEALTH
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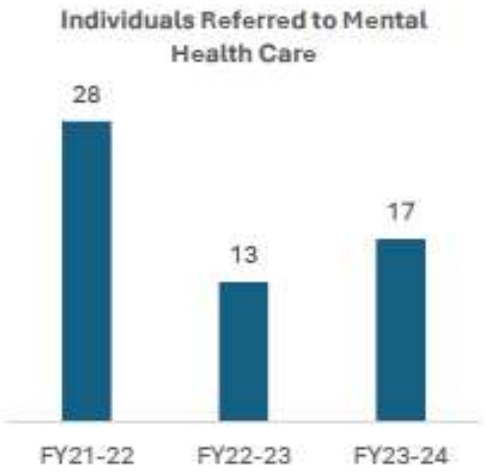
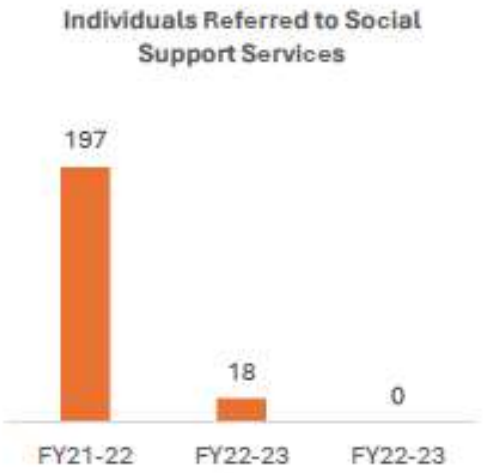
PROJECT ESPERANZA

Program Referrals

Program referrals include mental health care referrals to VCBH or other MHSA prevention, early intervention, or treatment programs. Referrals were also made to social supports such as food, housing, health insurance, and other support services.





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PROJECT ESPERANZA

Program Outcomes

Project Esperanza tracks outcomes for program participants (e.g., individuals who attend the drop-in center) using the Schwartz Outcome Scale (SOS-10), a 10-item measure of psychological health. Higher scores on this measure indicate greater psychological well-being and lower levels of distress. The chart below compares intake and exit scores.

Schwartz Outcome Scale (SOS-10)*		FY 21-22 Intake = 50, Exit =52	FY 22-23 Intake = 29, Exit =28	FY 23-24 Intake = 50, Exit = 41
Minimal	Intake	-	90%	80%
	Exit	81%	82%	100%
Mild	Intake	-	7%	18%
	Exit	19%	18%	0%
Moderate	Intake	-	3%	2%
	Exit	0%	0%	0%
Severe	Intake	-	0%	0%
	Exit	0%	0%	0%

Each year:

Each year, participants reported minimal levels of distress, on average:
85% at Intake
88% at Exit

*Total score on the SOS-10 ranges from 0–60 and scores are categorized as minimal (40–59), mild (33–39), moderate (23–32), or severe (1–22) levels of distress.

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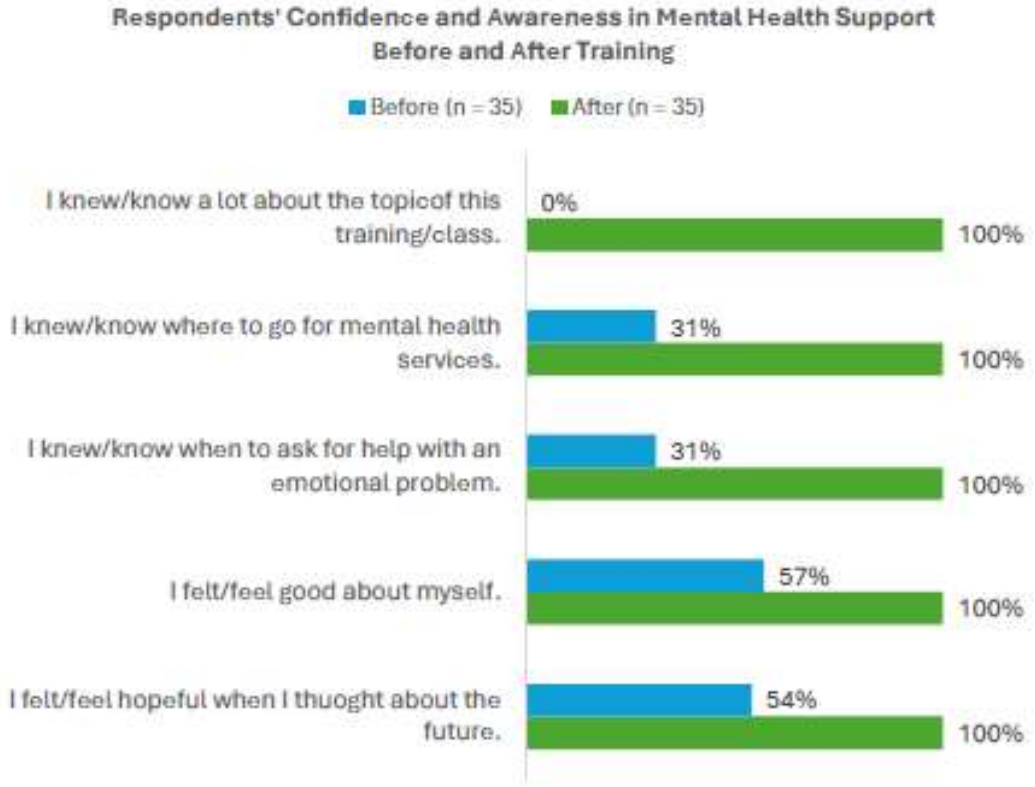
PROJECT ESPERANZA

Program Outcomes

Project Esperanza collected additional knowledge outcomes during FY 23-24. The chart below displays these results, reflecting responses from "Agree" or "Strongly Agree."



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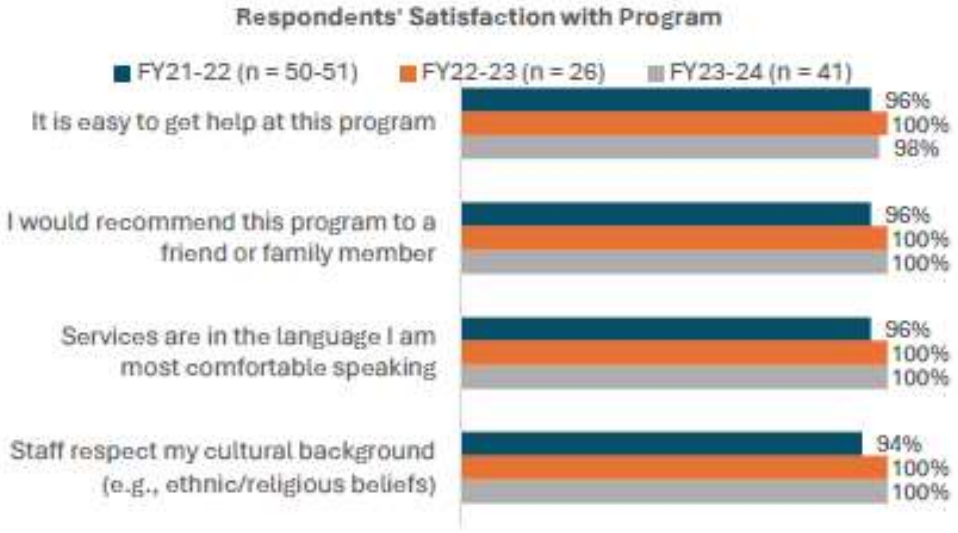
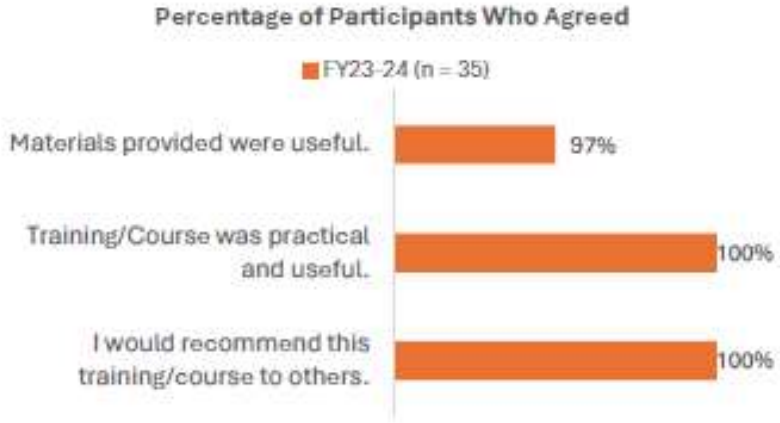
PROJECT ESPERANZA

Program Satisfaction

To measure their satisfaction with Project Esperanza, participants were asked to indicate the extent to which they disagreed or agreed with several statements about the program. The percentage of participants who agreed or strongly agreed with each statement is shown in the chart below.



In FY23-24, additional items were included to measure training satisfaction. Data from these items are presented in the chart below.



Virtually all participants were *completely satisfied* with Project Esperanza's program and staff.

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PROJECT ESPERANZA

Areas of Support

Participants were asked to select areas where they needed additional support from a provided list of options.* The chart below highlights the top support areas identified over the past three years.

FY21-22 (n = 54)

- Mental health: **76%**
- Relationships with friends and family: **20%**
- Parenting; My school attendance: **11%**

FY22-23 (n = 28)

- Grades in school: **32%**
- School attendance; My Mental Health: **25%**
- Parenting: **21%**

FY23-24 (n = 35)

- Parenting: **51%**
- Mental health: **46%**
- Relationships with friends and family: **34%**

*Total percentage may exceed number of participants because they could choose more than one response option.

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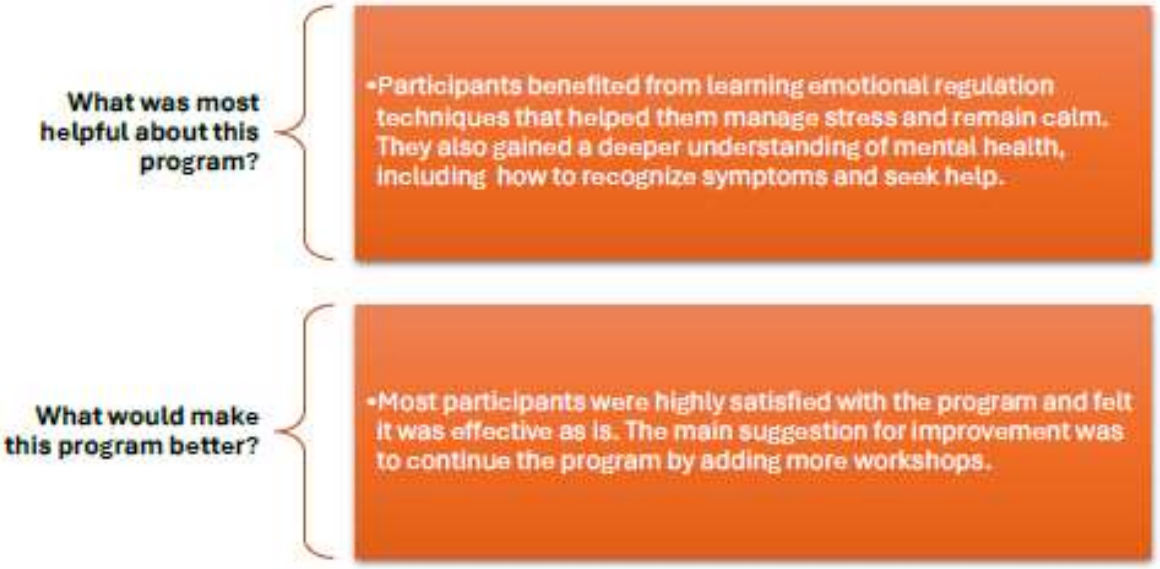
PROJECT ESPERANZA

Program Feedback

Participants who received program services from Project Esperanza were asked to provide additional feedback through two open-ended response questions. Their comments were categorized by theme, with the most common responses highlighted. Given that the program has evolved over the past three years, and staff has actively addressed previous challenges, only feedback specific to the fiscal year 2023-2024 is included in the chart below.



PROJECT ESPERANZA

Conclusions and Recommendations

Over the past three years, Project Esperanza has proven to be an asset for the Hispanic/Latino community in Santa Paula by addressing a range of mental health topics in a culturally sensitive manner. The program's focus on mental health literacy and a proactive approach to stigma reduction has likely contributed to positive participant knowledge and engagement shifts, as evidenced by workshop attendance and community outreach. The consistent delivery of mental health education on relevant topics, from technology use to suicide prevention, has fostered a supportive environment where community members feel empowered to discuss and learn about mental health. Participants have indicated a need for enhanced support in parenting, mental health, and relationships with family and friends. To address these needs effectively, increasing referral pathways to mental health care services and broadening access to social support services would be beneficial. By doing so, we can better align our resources with the specific challenges participants face and foster a more supportive community environment.

The program has experienced notable successes, including an increase in outreach materials distribution, reflecting effective communication and engagement strategies. This rise is mirrored by an increase in the number of individuals reached through outreach events, indicating a growing community presence. Additionally, the number of activities and outreach programs has expanded, demonstrating the program's commitment to offering diverse resources.

There has also been a decrease in the number of individuals receiving core program services, from 219 in FY 21-22 to 110 in FY 22-23, with a slight recovery to 122 in FY 23-24. To address this trend, Project Esperanza may consider implementing strategies to re-engage participants, helping the program adapt to the community's evolving needs and reinforce its role as a valuable resource for support and education.

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PROMOVIENDO PROGRAM
Promotoras y Promotores Foundation

The Promoviendo Program, referred to as Promotoras y Promotores Foundation (PyPF), primarily serves immigrant Latina/Hispanic women and their families who are at risk for depression and live throughout Ventura County. The Promoviendo Program facilitates community-based mental health support groups. It provides one-on-one support to empower and help participants reduce stress, manage depression, and improve their quality of life. In addition, the Promoviendo Program conducts outreach and community presentations to promote program services, distribute mental health educational information, increase awareness of local mental health resources, and educate the community on how to recognize signs of suicide risk and the effects of trauma (concept of "Situation, Options, Decide, Act [SODA]"). The Promoviendo Program expanded to twice its reach from FY 22-23 to FY 23-24 by its outreach into areas beyond the Santa Clara Valley, particularly Oxnard and Ventura cities.

Program Strategies

Improves timely access to services for underserved populations throughout Ventura County through referrals to culturally and linguistically appropriate services.

Implements non-stigmatizing and non-discriminatory practices by providing culturally and linguistically competent workshops and presentations.

VENTURA COUNTY BEHAVIORAL HEALTH
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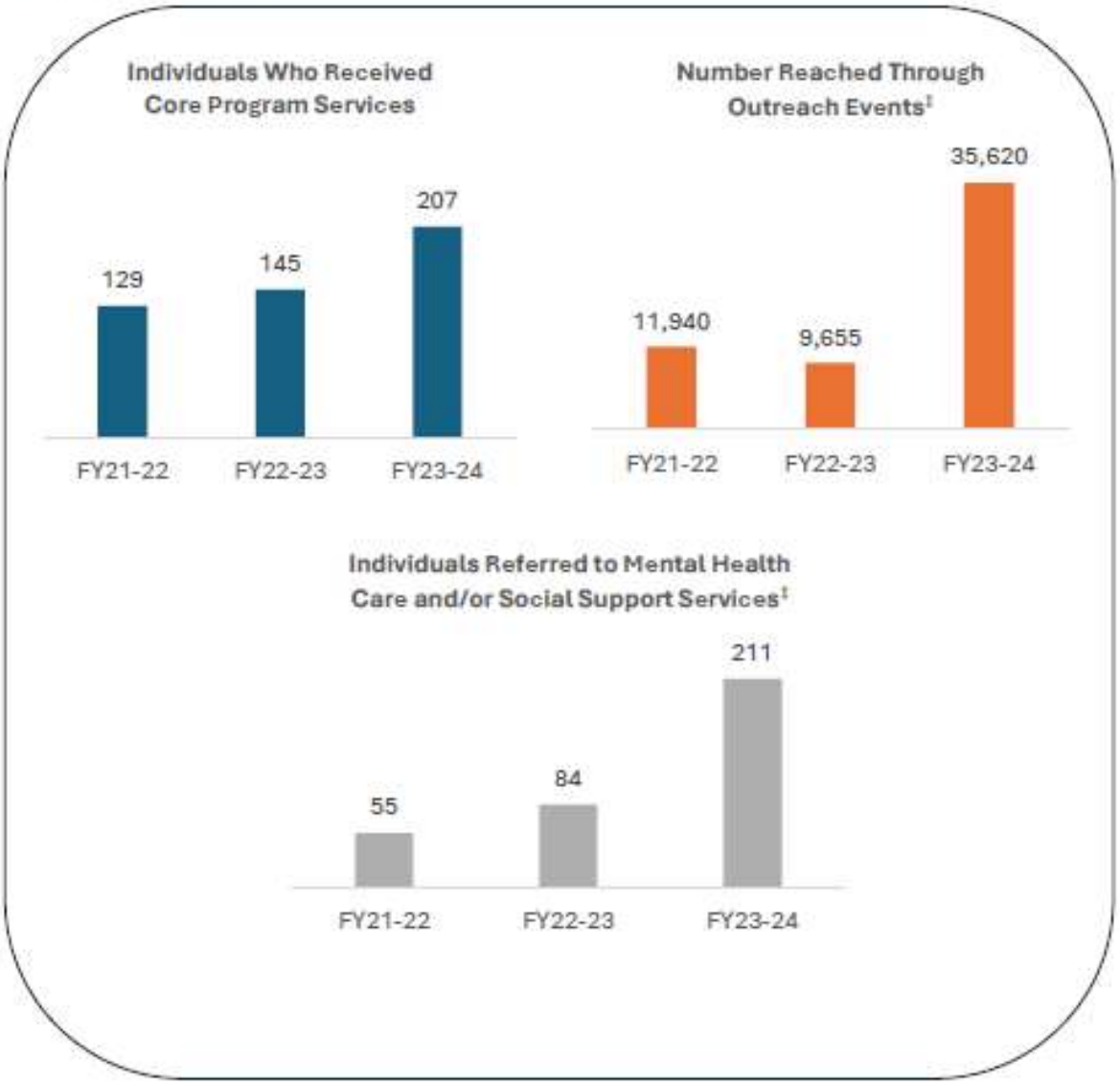
PROMOVIENDO PROGRAM

Program Highlights



‡Number of individuals may be duplicated

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PROMOVIENDO PROGRAM

Demographic Data

The Promoviendo Program collects unduplicated demographic data from the individuals they serve. This section presents information from 481 individuals who completed a demographic form over the past three years.

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Race*	**n = 102**	**n = 109**	**n = 192**
American Indian/Alaska Native	0%	0%	0%
Asian	0%	0%	1%
Black/African American	1%	0%	0%
Hispanic/Latino	25%	84%	93%
Native Hawaiian, other Pacific Islander	0%	0%	0%
White	76%	15%	16%
More Than One Race	0%	1%	0%
Other	0%	0%	0%
Ethnicity*	**n = 104**	**n = 104**	**n = 196**
Hispanic/Latino			
Caribbean	0%	0%	0%
Central American	0%	2%	3%
Mexican/Mex.-Am./Chicano	96%	98%	96%
Puerto Rican	0%	0%	1%
South American	0%	0%	0%
Other Hispanic/Latino	1%	0%	1%
Non-Hispanic/Latino			
African	1%	0%	0%
Asian Indian/South Asian	0%	0%	0%
Cambodian	0%	0%	0%
Chinese	0%	0%	0%
Eastern European	0%	0%	0%
European	0%	0%	0%
Filipino	0%	0%	0%
Japanese	0%	0%	0%
Korean	0%	0%	0%
Middle Eastern	0%	0%	0%
Vietnamese	0%	0%	0%
More than one	0%	0%	0%
Other Non-Hispanic/Latino	2%	0%	0%

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PROMOVIENDO PROGRAM

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Primary Language*	**n = 106**	**n = 106**	**n = 206**
English	9%	16%	14%
Spanish	93%	84%	93%
Indigenous (Mixtec or other)	-	-	1%
Age Groups	**n = 111**	**n = 111**	**n = 203**
0-15 years	6%	17%	22%
16-25 years	8%	6%	15%
26-59 years	54%	40%	55%
60+ years	32%	37%	8%
Gender Identity	**n = 118**	**n = 102**	**n = 206**
Male	14%	20%	32%
Female	86%	80%	67%
Transgender	0%	0%	0%
Genderqueer	0%	0%	0%
Questioning or Unsure	0%	0%	0%
Another Gender Identity	0%	0%	0%
Sex Assigned at Birth	**n = 100**	**n = 143**	**n = 185**
Male	14%	14%	34%
Female	86%	86%	66%
Sexual Orientation	**n = 87**	**n = 86**	**n = 166**
Heterosexual or Straight	100%	100%	100%
Gay or Lesbian	0%	0%	0%
Bisexual	0%	0%	0%
Queer	0%	0%	0%
Questioning or Unsure	0%	0%	0%
Another sexual orientation	0%	0%	0%
Disability	**n = 92**	**n = 96**	**n = 152**
Yes	5%	8%	2%
No	93%	92%	98%

VENTURA COUNTY BEHAVIORAL HEALTH
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PROMOVIENDO PROGRAM

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Disability Type*	**n = 5♦**	**n = 8♦**	**n = 3♦**
Chronic Health Condition/Chronic pain	20%	13%	0%
Dementia	0%	13%	0%
Developmental disability	20%	-	33%
Difficulty Hearing, or having speech understood	20%	25%	33%
Difficulty Seeing	40%	75%	67%
Another Communication Disability	0%	0%	0%
Learning Disability	0%	0%	33%
Mental Disability	0%	0%	-
Physical/Mobility Disability	20%	0%	0%
Another Mental Disability	0%	0%	0%
Another Disability	0%	13%	0%
Veteran	**n = 93**	**n = 102**	**n = 176**
Yes	0%	0%	0%
No	100%	100%	100%

*Total may exceed 100% because participants could choose multiple response options.

♦ Small sample sizes can make results less reliable and more affected by unusual values, so these findings should be interpreted cautiously.

From FY21-22 to FY23-24:

On average, Promoviendo is reaching a younger population

Male reach has increased 18%

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PROMOVIENDO PROGRAM

Program Activities & Outreach

Program activities include classes, meetings, support groups, trainings, and workshops facilitated by Promoviendo program staff. Program participants and other community members may participate in these activities and events.

Activity Type	FY 21-22	FY 22-23	FY 23-24
Social Support	249	-	-
Support Group	-	276	330
Total Activities	**249**	**276**	**330**

Program Outreach Type	FY 21-22	FY 22-23	FY 23-24
Outreach/Outreach Misc.	42	73	381
Presentation	1	3	17
Community Fair or Event	-	4	67
Faith-Based	-	1	-
Other	1	1	3
Total Outreach Activities	**44**	**82**	**468**

Metamorphosis Events

There were two Metamorphosis events hosted by PyPF and VCBH, one in FY 22-23 and one in FY 23-24. Both were very successful. Approximately 125 people attended the FY 22-23 event, and 150 people participated at the FY 23-24 event. The Metamorphosis events were designed for Spanish-speaking women and were conducted in Spanish. They featured speaker(s), lunch, an MHSA swag bag, community information tables with additional swag, and some drawings for gifts. Nearly all respondents scored a good or very good rating on the event date, registration process, venue, and resources provided. Also, most or all of the respondents thought the event was a valuable experience and would recommend this to a friend or colleague. The key speaker at both events, Dra. Dulce was well received, and the other three speakers were at the FY 23-24 event. The attendees considered these events valuable experiences and would recommend Metamorphosis to a client.

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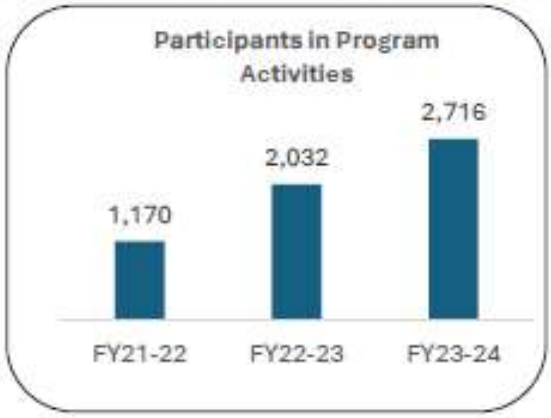
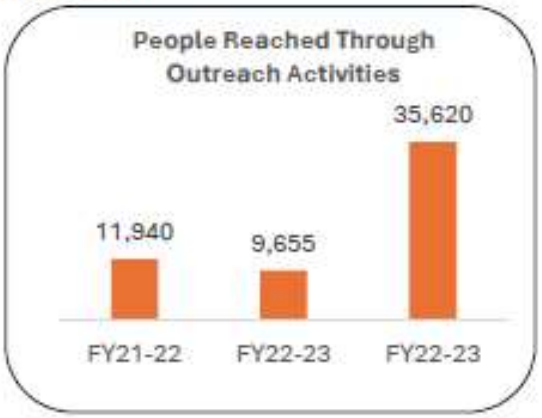
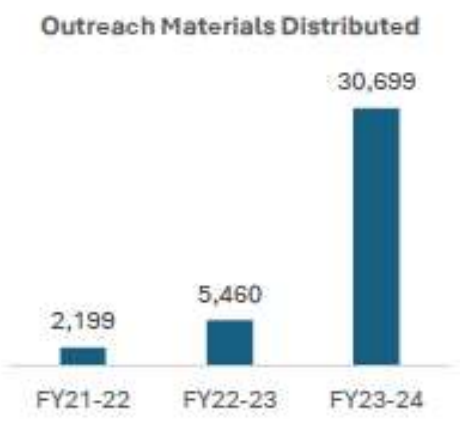
PROMOVIENDO PROGRAM

Program Activities & Outreach (continued)







From FY21-22 to FY23-24:

The number of participants in program activities increased by 34%

The number of outreach materials distributed increased by 462%

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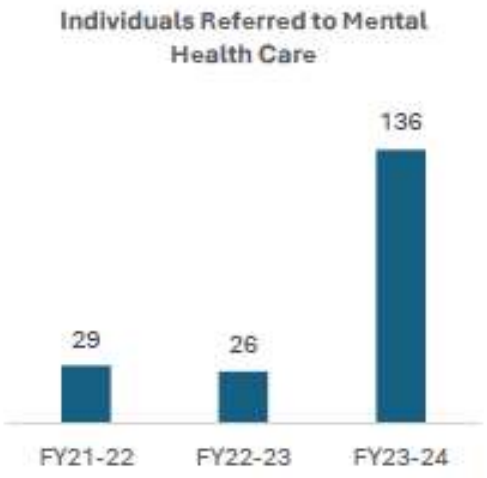
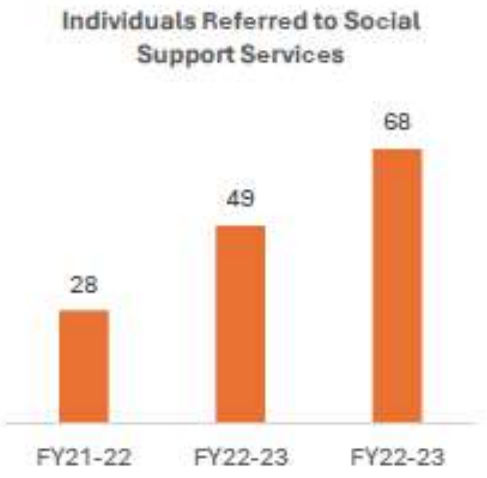
PROMOVIENDO PROGRAM

Program Referrals

Program referrals include referrals to social supports such as food, housing, health insurance, and other support services. Most referrals were made to Logrando Bienestar.





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PROMOVIENDO PROGRAM

Program Outcomes

The Promoviendo Program tracks outcomes for program participants (e.g., individuals who attend the drop-in center) using the Schwartz Outcome Scale (SOS-10), a 10-item measure of psychological health. Higher scores on this measure indicate greater psychological well-being and lower levels of distress. Comparisons of intake and exit scores are presented in the chart below.

Schwartz Outcome Scale (SOS-10)*		FY 21-22 Intake = 27, Exit =72	FY 22-23 Intake = 90, Exit =81	FY 23-24 Intake = 66, Exit = 101
Minimal	Intake	22%	77%	64%
	Exit	81%	96%	99%
Mild	Intake	11%	3%	6%
	Exit	8%	0%	1%
Moderate	Intake	15%	13%	15%
	Exit	10%	4%	0%
Severe	Intake	52%	7%	15%
	Exit	1%	0%	0%

Each year:

Each year, participants reported minimal levels of distress, on average:
53% at Intake
92% at Exit

*Total score on the SOS-10 ranges from 0-60 and scores are categorized as minimal (40-59), mild (33-39), moderate (23-32), or severe (1-22) levels of distress.

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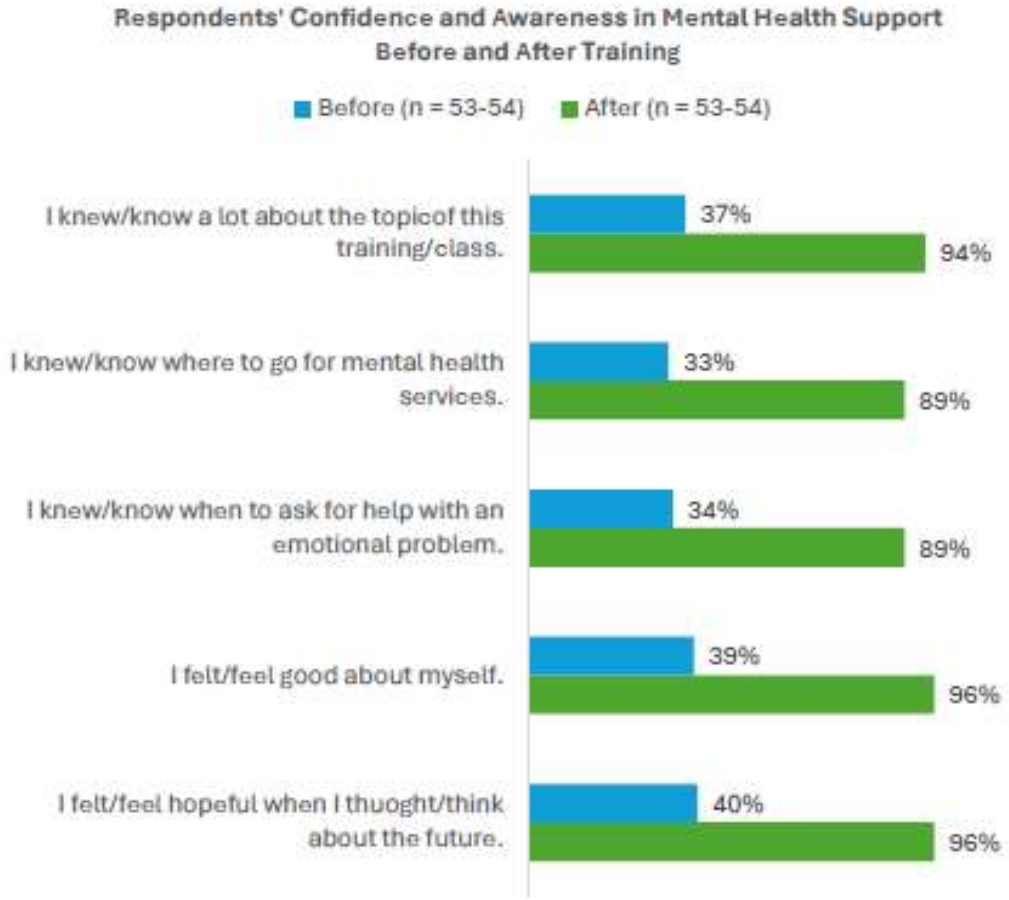
PROMOVIENDO PROGRAM

Program Outcomes

The Promoviendo Program gathered supplementary outcomes related to knowledge during FY23-24. The chart below illustrates the results from participants who either agreed or strongly agreed with the statements presented.



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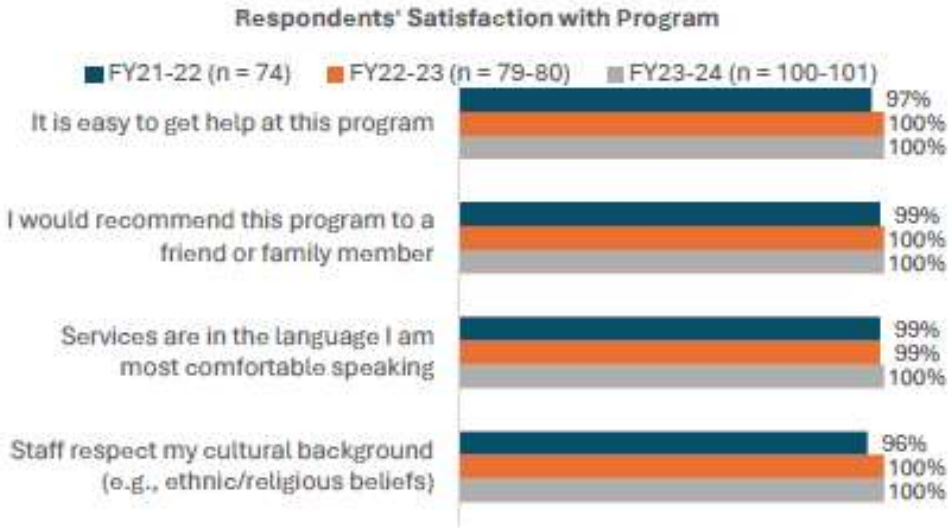
PROMOVIENDO PROGRAM

Program Satisfaction

Participants were asked to indicate the extent to which they disagreed or agreed with several statements about the program as a measure of their satisfaction with the Promoviendo program, staff, and services. The percentage of participants who agreed or strongly agreed with each statement is shown in the chart below.



In FY23-24, additional items were included to measure program satisfaction. Data from these items are presented in the chart below.

Virtually all participants were *completely satisfied* with Promoviendo's program and staff.

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PROMOVIENDO PROGRAM

Areas of Support

Participants were asked to select areas where they needed additional support from a provided list of options. The chart below highlights the top areas of support identified over the past three years.

FY21-22 (n = 74)
- Mental health: **73%**
- Relationships with friends and family: **43%**

FY22-23 (n = 81)
- Mental health: **67%**
- Relationships with friends and family: **44%**

FY23-24 (n = 152)
- Mental health: **96%**
- Relationships with friends and family: **43%**

*Total percentage may exceed number of participants because they could choose more than one response option.

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PROMOVIENDO PROGRAM

Program Feedback

Participants who received program services from Promoviendo were asked to provide additional feedback through two open-ended response questions. Their comments were categorized by theme, with the most common responses highlighted. Given that the program has evolved over the past three years, and staff have actively addressed previous challenges, only feedback specific to fiscal year 2023-2024 is included in the chart below.

What was most helpful about this program?	•Participants valued information about community resources and support groups. They appreciated learning breathing and relaxation techniques for mangaging stress, and enjoyed the flexibility of attending classes at their convenience.
What would make this program better?	•Participants requested more presentations and the formation of additional groups to reach a broader audience. They also suggested incorporating more activities and examples to help them stay focused and learn more effectively.

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PROMOVIENDO PROGRAM

Conclusions and Recommendations

The Promoviendo Program has made substantial strides in serving immigrant Latina/Hispanic women and their families at risk for depression throughout Ventura County. The program has fostered a supportive environment that engages participants through community-based mental health support groups, one-on-one assistance, and educational outreach. This growth in program involvement highlights the program's ability to attract and retain community members, while extensive outreach efforts demonstrate a strong commitment to raising awareness and providing valuable resources.

The program has positively impacted participants' psychological well-being, as reflected in the Schwartz Outcome Scale (SOS-10) data. The improvement in scores between intake and exit assessments underscores the effectiveness of the support provided in enhancing mental health and reducing distress. Additionally, participant feedback reveals high satisfaction with the culturally and linguistically appropriate services offered, indicating that these tailored approaches resonate well with the community's needs.

To further strengthen its impact, the program is encouraged to expand referral pathways to mental health care and social support services, ensuring comprehensive resource access for participants. Enhancing educational workshops on stress-coping strategies and family dynamics will empower participants with the knowledge and skills to improve their overall quality of life. Continuously collecting and analyzing participant feedback will help identify areas for improvement and allow the program to adapt to meet the community's evolving needs effectively.

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TRI-COUNTY GLAD

Tri-County GLAD serves Deaf and Hard of Hearing (DHH) individuals of all ages. The program offers educational workshops and trainings about mental health topics and provides community organizations with information on the mental health needs of the DHH community. Tri-County GLAD also provides referrals to mental health care.

Program Strategies

Increases recognition of early signs of mental illness by providing trainings to educators and other potential responders.

Implements non-stigmatizing and non-discriminatory practices by dispelling myths about DHH individuals and sharing information about DHH in English and Spanish.

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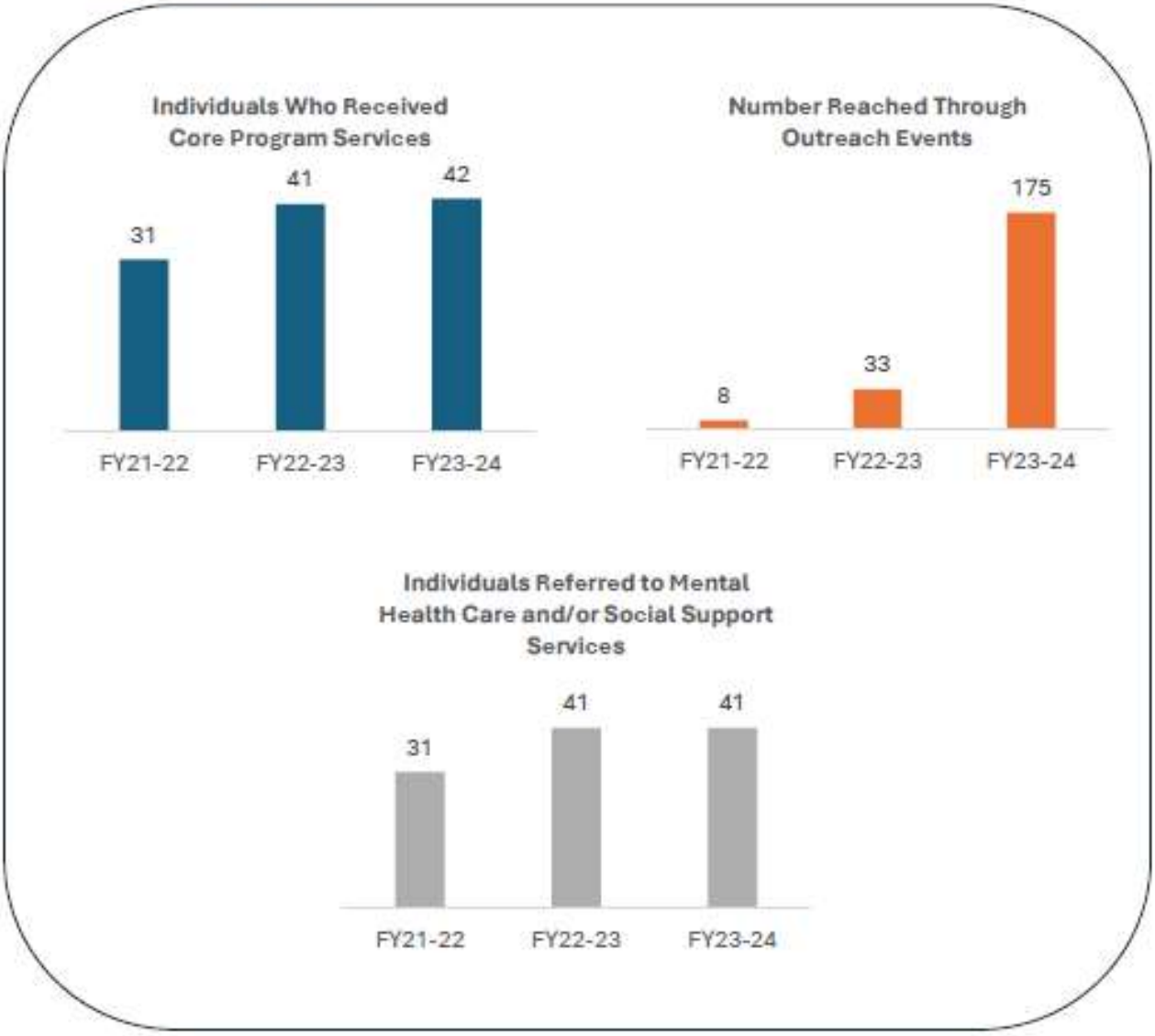
TRI-COUNTY GLAD

Program Highlights



TRI-COUNTY GLAD

Demographic Data

Tri-County GLAD collects unduplicated demographic data from the individuals they serve. This section presents information from 125 individuals who completed a demographic form over the past three years.

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Race*	**n = 30**	**n = 41**	**n = 42**
American Indian/Alaska Native	0%	0%	5%
Asian	3%	2%	10%
Black/African American	0%	0%	0%
Hispanic/Latino	37%	51%	43%
Native Hawaiian, other Pacific Islander	0%	2%	2%
White	57%	39%	45%
More Than One Race	3%	5%	10%
Other	0%	0%	0%
Ethnicity*	**n = 29**	**n = 41**	**n = 42**
Hispanic/Latino			
Caribbean	0%	0%	0%
Central American	3%	2%	0%
Mexican/Mex.-Am./Chicano	35%	46%	43%
Puerto Rican	0%	0%	0%
South American	0%	5%	0%
Other Hispanic/Latino	0%	0%	2%
Non-Hispanic/Latino			
African	0%	0%	0%
Asian Indian/South Asian	3%	0%	2%
Cambodian	0%	0%	0%
Chinese	0%	0%	0%
Eastern European	0%	2%	2%
European	59%	44%	45%
Filipino	0%	2%	7%
Japanese	0%	0%	0%
Korean	0%	0%	0%
Middle Eastern	0%	0%	0%
Vietnamese	0%	0%	0%
More than one	0%	0%	0%
Other Non-Hispanic/Latino	0%	0%	0%

VENTURA COUNTY
BEHAVIORAL HEALTH
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TRI-COUNTY GLAD

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Primary Language*	**n = 31**	**n = 41**	**n = 42**
English	0%	12%	62%
Spanish	0%	0%	12%
Indigenous (Mixtec or other)	0%	0%	0%
Another Language♦	100%	100%	93%
Age Groups	**n = 31**	**n = 39**	**n = 42**
0-15 years	3%	8%	12%
16-25 years	3%	8%	26%
26-59 years	65%	67%	45%
60+ years	29%	18%	17%
Gender Identity	**n = 31***	**n = 41**	**n = 42**
Male	-	41%	38%
Female	-	59%	60%
Transgender	-	0%	0%
Genderqueer	-	0%	2%
Questioning or Unsure	-	0%	0%
Another Gender Identity	-	0%	0%
Sex Assigned at Birth	**n = 31**	**n/a***	**n = 37**
Male	29%	-	41%
Female	71%	-	59%
Sexual Orientation	**n = 31***	**n = 39**	**n = 42**
Heterosexual or Straight	-	90%	88%
Gay or Lesbian	-	10%	10%
Bisexual	-	0%	2%
Queer	-	0%	0%
Questioning or Unsure	-	0%	0%
Another sexual orientation	-	0%	0%
Disability	**n = 30**	**n = 41**	**n = 42**
Yes	100%	100%	100%
No	0%	0%	0%

VENTURA COUNTY
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TRI-COUNTY GLAD

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Disability Type*	**n = 30**	**n =41**	**n = 42**
Seeing	6%	2%	5%
Hearing	100%	100%	100%
Another Communication Disability	0%	0%	2%
Learning Disability	0%	0%	2%
Developmental Disability	3%	5%	2%
Dementia	0%	0%	0%
Another Mental Disability	0%	0%	2%
Physical/Mobility Disability	0%	2%	7%
Chronic Health Condition/Chronic pain	0%	0%	5%
Another Disability	-	0%	5%
Veteran	**n = 31**	**n = 41**	**n = 42**
Yes	0%	0%	0%
No	100%	100%	100%

*Total may exceed 100% because participants could choose multiple response options.
^ All participants selected "Decline to Answer" in FY21-22.
♦ Selected ASL as an Other Language.
* Data not collected.

VENTURA COUNTY BEHAVIORAL HEALTH
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TRI-COUNTY GLAD

Program Activities & Outreach

Program activities include classes, counseling, meetings, support groups, trainings, and workshops facilitated by program staff. Program participants and other community members may participate in these activities and events.

Activity Type	FY 21-22	FY 22-23	FY 23-24
Training/Workshop	20	23	13
Other	2	-	-
Total Activities	**22**	**23**	**13**

21 individuals received 246 hours of counseling in FY 23-24

Program Outreach Type	FY 21-22	FY 22-23	FY 23-24
Community Fair or Event	1	2	-
Total Outreach Activities	**1**	**2**	**-**

From FY21-22 to FY23-24:

The number of participants in program activities decreased by 77%†

†Number of people reached may be duplicated because individuals could attend multiple activities.

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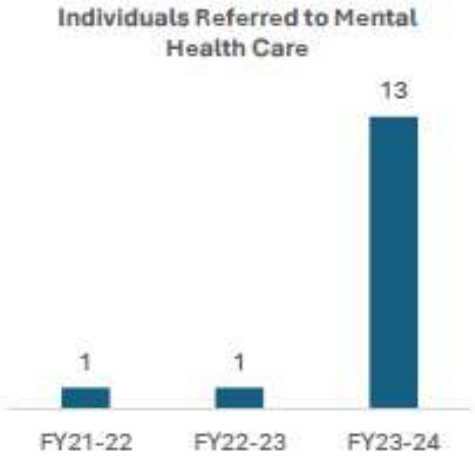
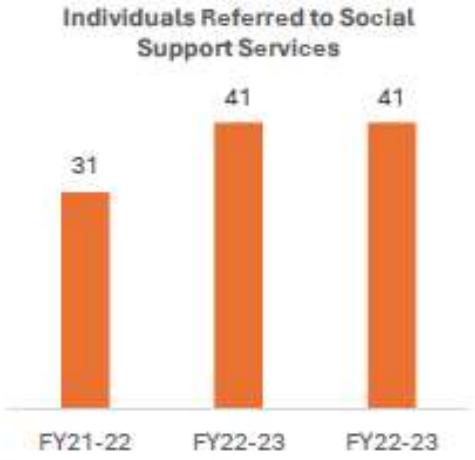
TRI-COUNTY GLAD

Program Referrals

Program referrals include mental health care referrals to VCBH or other MHSA prevention, early intervention, or treatment programs, as well as referrals to social support services such as food, housing, health insurance, and other assistance. The figures below illustrate the number of individuals who received these referrals over the past three years.





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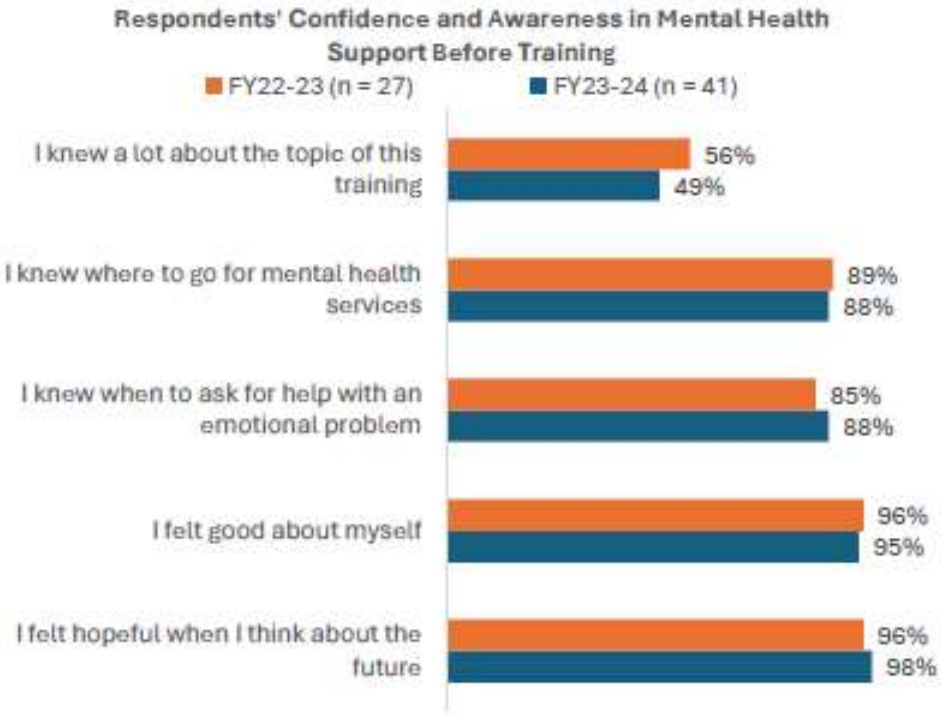
TRI-COUNTY GLAD

Program Outcomes

Tri-County GLAD tracks program outcomes by asking participants to self-assess their knowledge from two perspectives (retrospective pre/post): before and after they received services. In FY 21-22, participants reported an average difference of 46% in knowledge after receiving services. Revisions to the data tool were made after FY 21-22, and FYs 22-23 and 23-24 results are presented in the charts below.



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TRI-COUNTY GLAD

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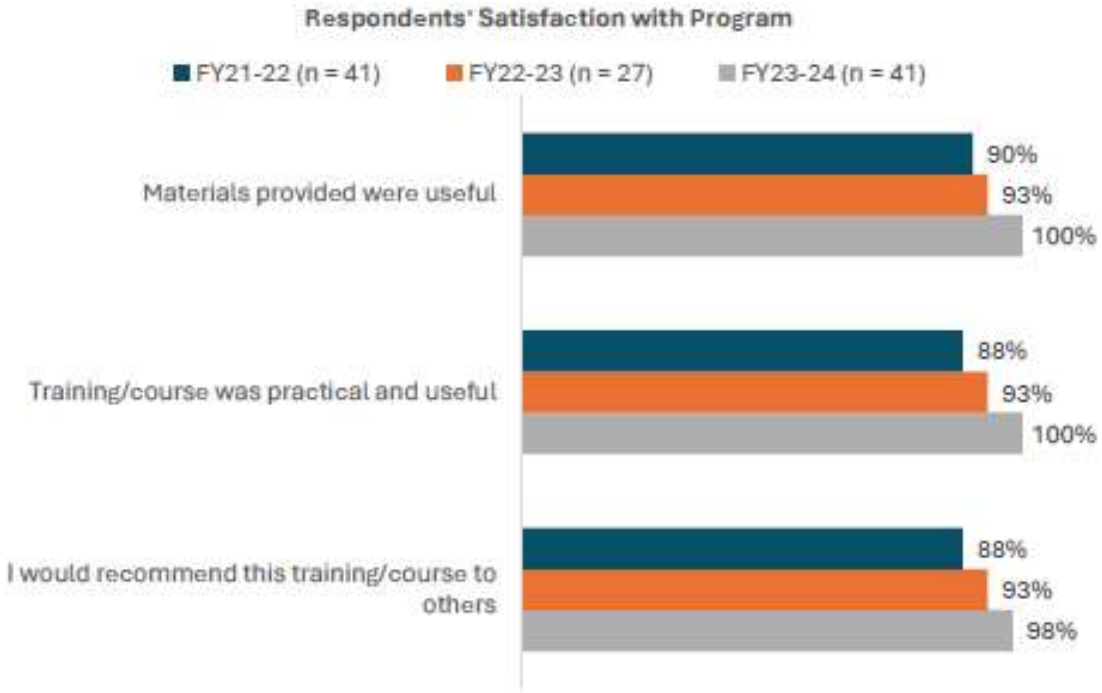
TRI-COUNTY GLAD

Program Satisfaction

Participants and trainees in Tri-County GLAD services were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement over the past three years.



Most participants were *completely satisfied* with Tri-County GLAD's trainings/courses.

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TRI-COUNTY GLAD

Areas of Support

Participants were asked to select areas where they needed additional support from a provided list of options. The list below highlights the top support areas identified over the past three years.

FY21-22 (n = 26)
- Mental health: **42%**
- Relationships with friends and family: **42%**
- Job : **38%**

FY22-23 (n = 20)
- Relationships with friends and family: **50%**
- Job: **40%**
- Mental health: **35%**

FY23-24 (n = 23)
- Mental health: **70%**
- Relationships with friends and family: **61%**
- Job: **35%**

*Total percentage may exceed number of participants because they could choose more than one response option.

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TRI-COUNTY GLAD

Program Feedback

Participants who received program services from Tri-County GLAD were asked to provide additional feedback through two open-ended response questions. Given that the program has evolved over the past three years, and staff has actively addressed previous challenges, only feedback specific to the fiscal year 2023-2024 is included in the chart below.

What was most helpful about this program?	•The program helped participants understand the differences between deaf and hard of hearing individuals and the specific communication challenges they face. The training was practical and helped participants make mental health services more acessing and effective for the DHH community.
What would make this program better?	•Some participants felt the presentation was too fast-paced and recommended more time be spent on each slide. They also suggested adding interactive elements (e.g., discussion questions, example videos) and recommended increasing the program's visibility in the community.

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TRI-COUNTY GLAD

Conclusions and Recommendations

Tri-County GLAD has made substantial progress in serving Deaf and Hard of Hearing (DHH) individuals across the past three years. The program has seen a steady increase in the number of individuals receiving core program services and a marked rise in outreach efforts. The expansion of educational workshops, trainings, and informational outreach has helped improve awareness around mental health and reduce stigma within the DHH community.

Feedback from participants indicates high satisfaction with the support and resources provided, although some have expressed a desire for a slower pace during presentations and the inclusion of interactive elements like discussion questions and videos. These suggestions could enhance engagement and retention of the material presented. The positive reception and constructive feedback highlight the program's effectiveness in addressing the unique needs of the DHH community while also suggesting areas for potential improvement.

To further enhance its impact, the program could consider increasing its community presence through more visible outreach efforts and strengthening its support for the DHH community, ensuring that mental health services are accessible, inclusive, and culturally relevant.

VENTURA COUNTY BEHAVIORAL HEALTH
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WELLNESS CENTERS EXPANSION
Ventura County Office of Education (VCOE)

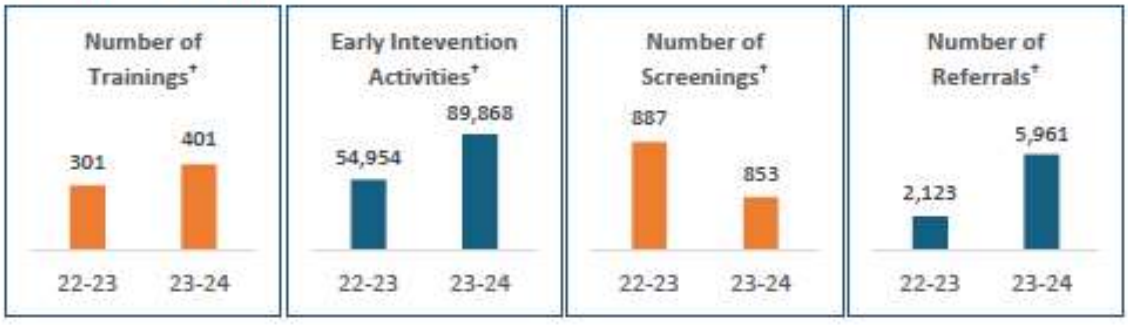
Beginning in Spring 2022, Ventura County Behavioral Health allocated funding to the Ventura County Office of Education to implement Wellness Centers in eleven middle school campuses as part of its Prevention and Early Intervention programming within MHSA. These Wellness Centers are classified as Prevention programs under MHSA, which are broadly defined as "a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors." The Wellness Centers are designed to implement strategies that increase early identification of mental health needs, reduce access barriers, prevent mental health issues from becoming severe and disabling, and facilitate connections to ongoing and sustained services by leveraging resources and integrating funding sources. The first cohort of fifteen Wellness Centers began service implementation in the Fall 2022 school year. Following the successes of the first cohort, a second cohort of 14 schools began service implementation in the Fall 2023 school year.

Program Strategies

Provides access and linkage to services for those with serious mental illness and serious emotional disturbance.

Implements non-stigmatizing and non-discriminatory practices by providing culturally competent, evidence-based trainings to educators to support students from underserved and underrepresented groups.

Program Highlights‡*



‡This program did not provide demographic information.

†Number of individuals may be duplicated.

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WELLNESS CENTERS EXPANSION

Wellness Center Goals

1. Prevent mental illness from becoming severe and debilitating
2. Reduce risk factors that negatively affect mental health and academic success
3. Improve access to school-based mental health services

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WELLNESS CENTERS EXPANSION

Wellness Center Schools

Districts	Schools
Conejo Valley Unified School District (CVUSD)	Century Academy Colina Middle School Los Cerritos Middle School Redwood Middle School Sequoia Middle School Sycamore Middle School
Fillmore Unified School District (FUSD)	Fillmore Middle School
Hueneme Elementary School District	E. O. Green Jr. High School
Moorpark Unified School District	Arroyo West Elementary Campus Canyon (K-8) Chaparral Middle School Flory Elementary School Mesa Verde Middle School Mountain Meadows Elementary Peach Hill Elementary Walnut Canyon Elementary
Oak Park Unified School District	Oak Park High School
Ojai Unified School District (OUSD)	Nordhoff Jr. High School
Oxnard School District (OSD)	Dr. Manual M. Lopez Academy Fremont Academy R.J. Frank Academy
Pleasant Valley School District (PVSD)	Las Colinas Middle School Monte Vista Middle School
Santa Paula Unified School District (SPUSD)	Isbell Middle School
Ventura County Office of Education (VCOE)	Gateway Community School
Ventura Unified School District	Anacapa Middle School Balboa Middle School Cabrillo Middle School DATA Middle School

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WELLNESS CENTERS EXPANSION

Program Activities

Wellness centers document program activities such as staff and student training, family engagement activities, screenings, referrals, and early intervention activities.

Trainings and Events	FY 22-23	FY 23-24
Staff and Student Trainings	191	293
Family Trainings and Events	110	108
TOTAL # of Trainings/Events	**301**	**401**
Early Intervention Services		
School-based Individual Services	4,777	4,830
School-based Group Services	24,944	22,624
Other	25,233	62,414
TOTAL # of Intervention Services	**54,954**	**89,868**

Additional information about these activities is available upon request. These data are organized by school years, not fiscal years.

Program Referrals

Program referrals include those made to school-based group or individual therapy, community-based mental health services, and/or other support services as needed. Contracted school districts conducted screenings of students' social, educational, and mental health needs to determine the need for service.

Screenings and Referrals	22-23	23-24
Screenings	887	853
Individual School-Based Referrals	412	983
Group School-Based Referrals	666	3,967
Community-Based Referrals	144	92
Other Referrals	14	66
TOTAL # of Referrals	**2,123**	**5,961**

*These data are organized by school years, not fiscal years.

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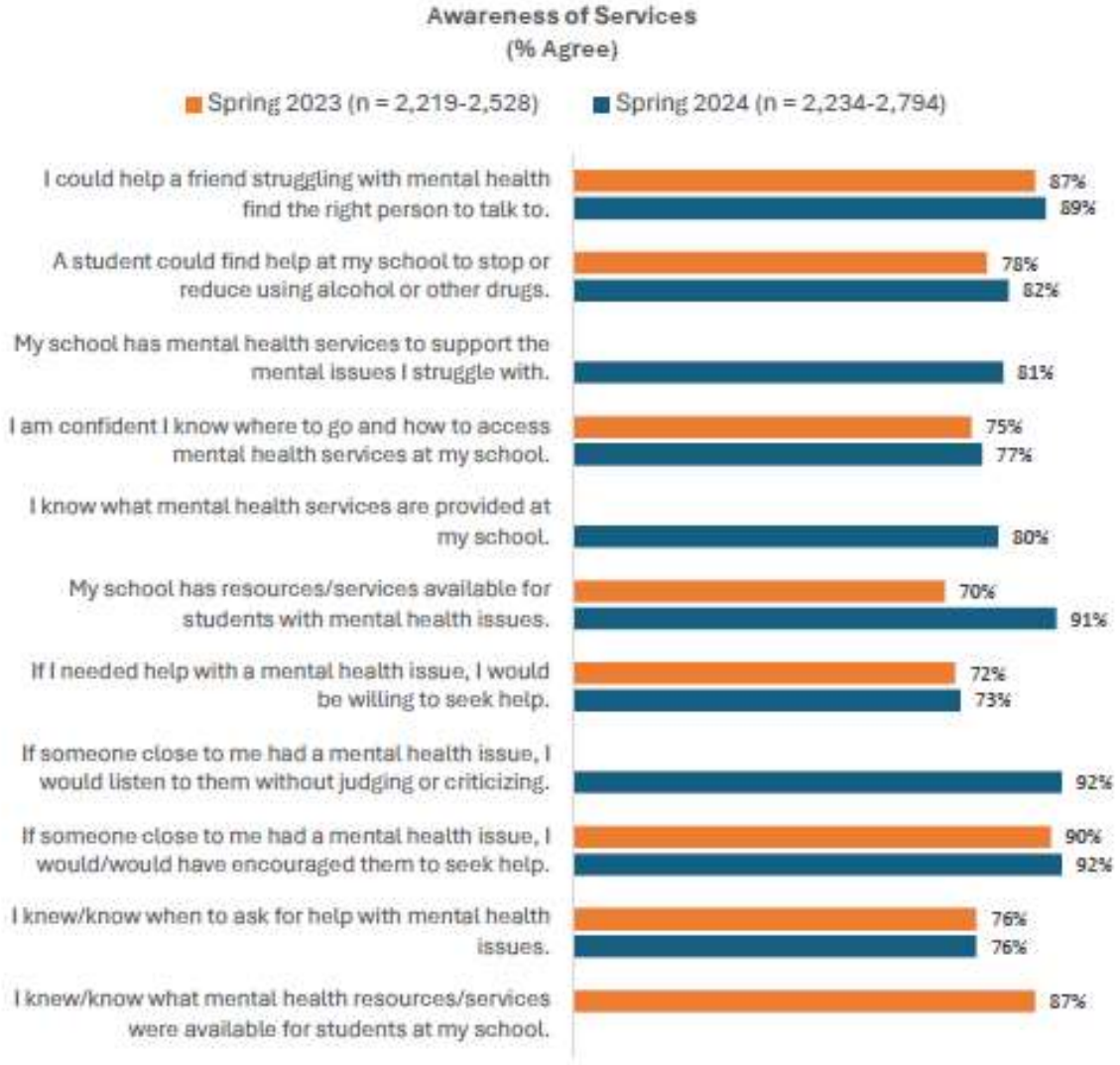
WELLNESS CENTERS EXPANSION

Program Outcomes

A Mental Health Access and Awareness pre/post survey was digitally administered to all students to evaluate changes in student awareness of the Wellness Centers and other school-based services, as well as student attitudes toward seeking help for oneself and others at the beginning and end of the school year. Results on awareness of services at the beginning and end of the school year, as well as attitudes toward seeking help for oneself at the beginning and end of the school year, are presented in the charts below. More information regarding survey results is available upon request.



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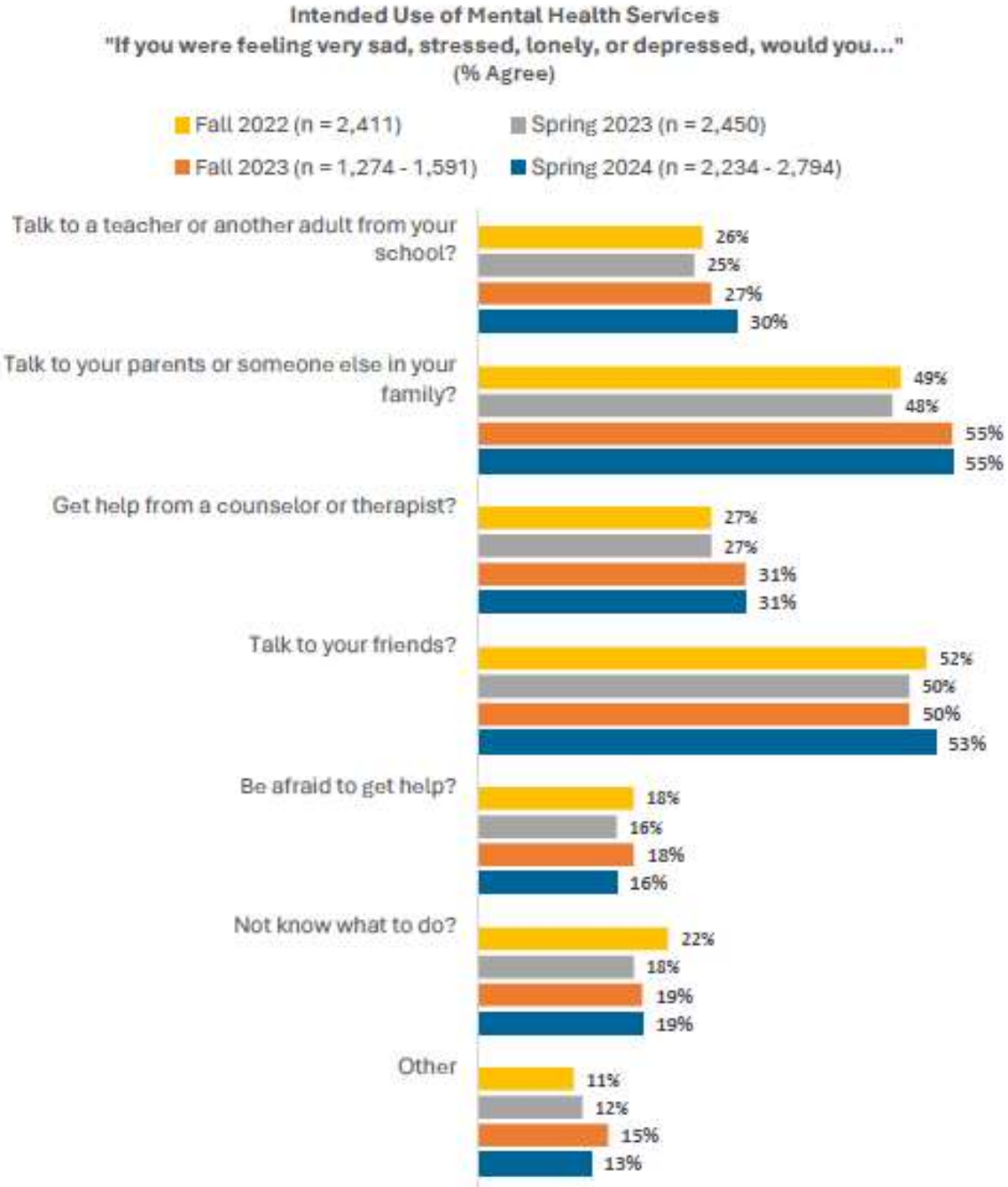
WELLNESS CENTERS EXPANSION



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WELLNESS CENTERS EXPANSION

Successes and Challenges

Across the 29 schools, challenge and success stories were shared. Representative challenges shared include:

- **High demand for services**: Increasing need for mental health support among students.
- **Staff shortages**: Insufficient personnel to meet the growing demand for services.
- **Initial setup challenges**: Difficulties in establishing space and implementing services for the first time, including setting ground rules.
- **Balancing student needs**: Navigating the requirement for both quiet and social spaces to accommodate different student preferences.
- **Protecting sensory items**: Challenges in providing fidget and sensory stimulation items without them being stolen or damaged.
- **Engaging parents**: Need for improved strategies to involve parents in the Wellness Center initiatives.

Representative success stories shared include:

- **High student utilization:** Significant engagement with the Wellness Centers by students.
- **Effective integration of peer mentors**: Enhanced support and community within the centers.
- **Positive reception from stakeholders**: Strong support from parents and the school board.
- **Individual success stories**: Tangible benefits experienced by students who engage with the centers.
- **Successful themed events**: Implementation of activities like Mental Health Awareness Month and Anti-Bullying Prevention Spirit Week to raise awareness and promote a supportive school culture.

"There has been a shift in school culture across our middle schools in recognition of the importance of social-emotional support. The schools have implanted school-wide social-emotional learning and have been increasingly identifying and referring students for wellness

"This past quarter has been amazing for our growth as a Wellness Center. The Wellness Peers have really stepped up and realized that putting yourself out there is growth and pays off. Our students took a safety survey and indicated that they feel that the school does a lot to support their mental health and they know where to go if they need support."

VENTURA COUNTY
BEHAVIORAL HEALTH
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WELLNESS CENTERS EXPANSION

Summary and Recommendations

Over the first two years of implementing the Middle School Wellness Centers, the initiative has made significant strides in raising awareness and increasing students' confidence in accessing mental health services. By the end of both years, nearly 90% of students were aware of the Wellness Centers, with about 40-50% of students having visited them. Students also reported an increased willingness to seek help and greater confidence in understanding how to access services.

While 55% of students would talk to family about their mental health concerns, only 30% would approach a teacher or another school adult. About 31% of students expressed they would seek help from a counselor or therapist, and 16-18% still reported fear or uncertainty in seeking help. These findings indicate the need for targeted efforts to improve students' comfort in accessing school-based support.

The Access and Awareness Survey data further highlights positive service awareness trends. By Spring 2024, 89% of students felt confident they could help a friend find the right support for mental health issues, and 77% knew how to access mental health services at school, a slight increase from the previous year. Awareness of substance abuse support at schools also rose, with 82% of students reporting that they could find help for alcohol or drug-related issues. However, there are still areas needing attention, such as increasing students' confidence in knowing what services their schools offer, especially for those who might struggle with mental health issues themselves.

Key Recommendations:
The following summarizes the recommendations from open-ended responses on the tracking logs, as well as interviews of Wellness Center coordinators:

1. **Optimize Space and Implementation:** Improve Wellness Center facilities and establish clear service delivery protocols.
2. **Expand Substance Abuse Interventions:** Strengthen partnerships with local agencies and increase prevention workshops to meet growing needs.
3. **Enhance Translation Services:** Expand language support to accommodate students from diverse linguistic backgrounds.
4. **Promote Parental Engagement:** Simplify consent processes and offer more parent-focused workshops to reduce cultural barriers and stigmas.
5. **Encourage School-Based Support:** Increase efforts to make students more comfortable seeking help from school staff, as only 30% of students indicated they would approach a teacher or counselor.
6. **Streamline Referrals:** Simplify off-campus referral processes and collaborate with community organizations to improve accessibility.
7. **Improve Data Collection:** Ensure consistent survey administration and better alignment with program goals to accurately measure the impact of services.

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WELLNESS EVERYDAY AND STAY MEDIA CAMPAIGN
Idea Engineering, Inc.

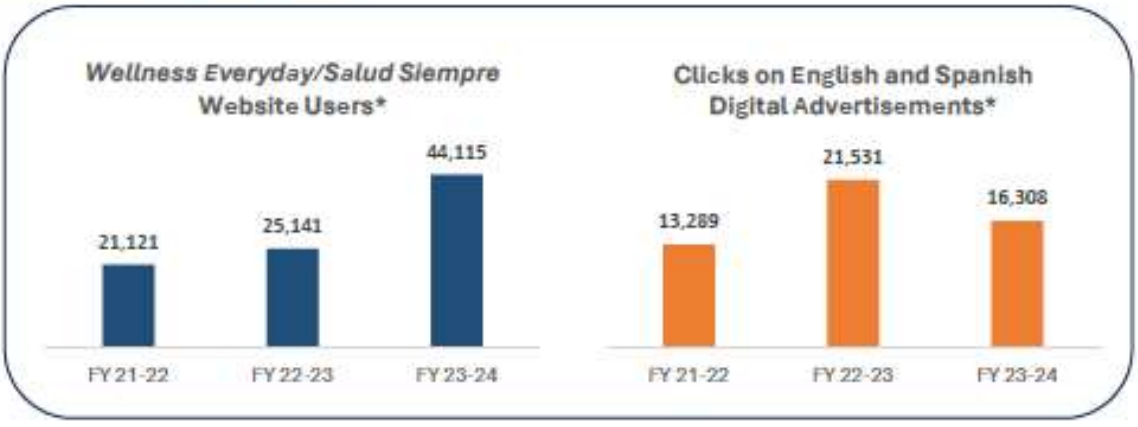
Wellness Everyday provides universal prevention messaging regarding mental health throughout Ventura County, via traditional and digital media channels. The *Wellness Everyday/Salud Siempre* website, available in English and Spanish, provides educational information about mental health and wellness and suicide prevention, as well as contact/referral information for local resources/supports (including some MHSA-funded programs). The STAY Media Campaign ("Quédate" in Spanish) is designed to prevent suicide attempts and connect individuals to resources. Information is disseminated through digital, traditional, and location-based media. While Wellness Everyday and the STAY Media Campaign are separate programs, FY 23/24 data has been combined into this report.

Program Strategies

Distributes mental health, wellness, and suicide prevention advertisements in English and Spanish through traditional media such as radio, transit and newspapers, digital media such as social media advertising and targeted website advertisements, and location-based advertisements across Ventura County.

Provides mental health and wellness information and resources in English and Spanish through the *Wellness Everyday/Salud Siempre* website.

Program Highlights[1]



[1]This program does not provide referral information or demographic information.

*May include duplicate users.

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WELLNESS EVERYDAY

Demographic Data†

The *Wellness Everyday/Salud Siempre* website cannot capture detailed user demographic data. Instead of standardized demographic information aligned with PEI regulations, data about geographic location (note that website traffic reports include all of California) and device type are presented for website sessions. Data in which location information was available are presented separately for the English and Spanish versions of the website. The top five locations reached for the past three years are given below.

Top 5 Locations Reached in FY 21-24 – Wellness Everyday

- Ventura
- Thousand Oaks
- Camarillo
- Oxnard
- Simi Valley

Top 5 Locations Reached in FY 21-24 – Salud Siempre‡

- Oxnard
- Simi Valley
- Santa Paula
- Ventura
- Thousand Oaks

†May include duplicate users.

‡Camarillo was a Top 5 location in FY 21-22, tying with Santa Paula

*Ventura County residents commuting outside the County may affect the tracking of location-based metrics. Beyond this, privacy and technological restrictions affect the capacity to collect accurate geographical data. Given the local resources on the website and the local targeting of media, it can be reasonably assumed that most website visitors are local to Ventura County.

VENTURA COUNTY BEHAVIORAL HEALTH
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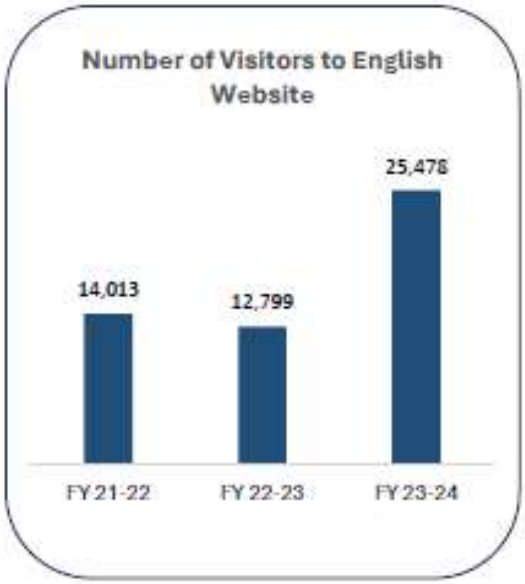
WELLNESS EVERYDAY

Website Sessions by Device Type

Sessions by Device Type: English Website	FY 21-22 (n=17,556)	FY 22-23 (n=16,481)	FY 23-24 (n=25,478)
Mobile	56%	57%	49%
Desktop	41%	39%	45%
Tablet	3%	4%	6%

Sessions by Device Type: Spanish Website	FY 21-22 (n=8,280)	FY 22-23 (n=14,442)	FY 23-24 (n=18,637)
Mobile	66%	77%	61%
Desktop	31%	21%	33%
Tablet	3%	2%	7%

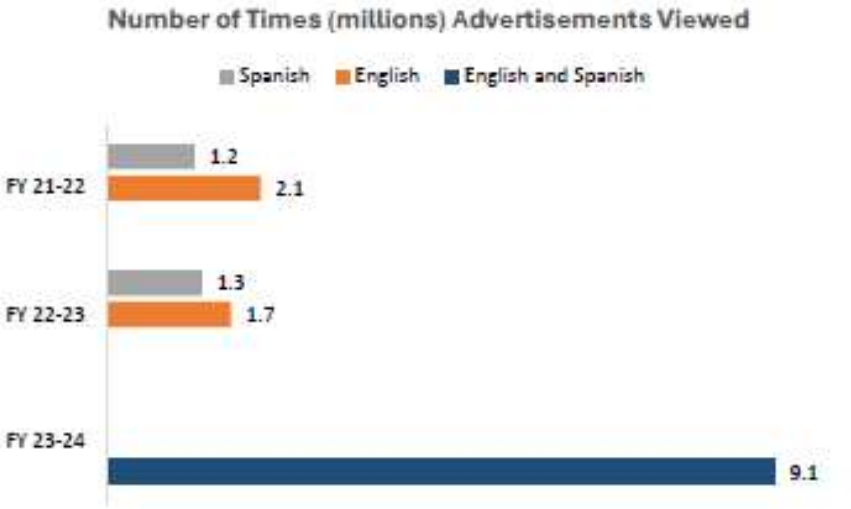
Website Traffic

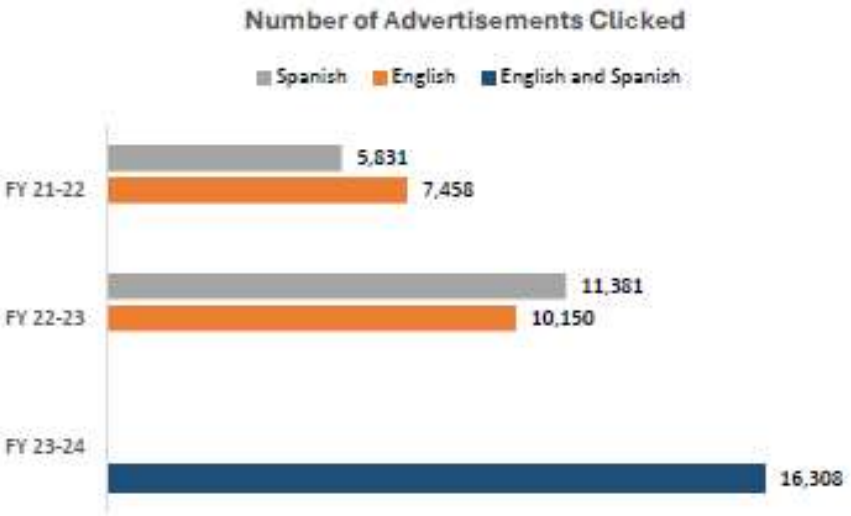


WELLNESS EVERYDAY

Media Advertisements

Idea Engineering used social media, newspaper ads, targeted ads on websites, and traditional advertisements such as radio, broadcast television, and cable television across various Wellness Everyday campaigns.





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STAY MEDIA CAMPAIGN

Idea Engineering used targeted ads on websites, location-based advertisements across various locations within Ventura County, and traditional radio, broadcast, and cable television advertisements across the STAY Media campaigns*.

TRADITIONAL MEDIA
Broadcast TV
Cable TV
Radio

DIGITAL MEDIA
Online Video
Streaming Video
Display Ads
YouTube

LOCATION-BASED MEDIA
Mobile Billboard (LED Truck)
Transit (Bus) Ads
Digital Billboards
Digital Mall Signs
Mall Pole Banners
Hispanic Indoor Media
(Laundromats & Salons)
Movie Theater Ads

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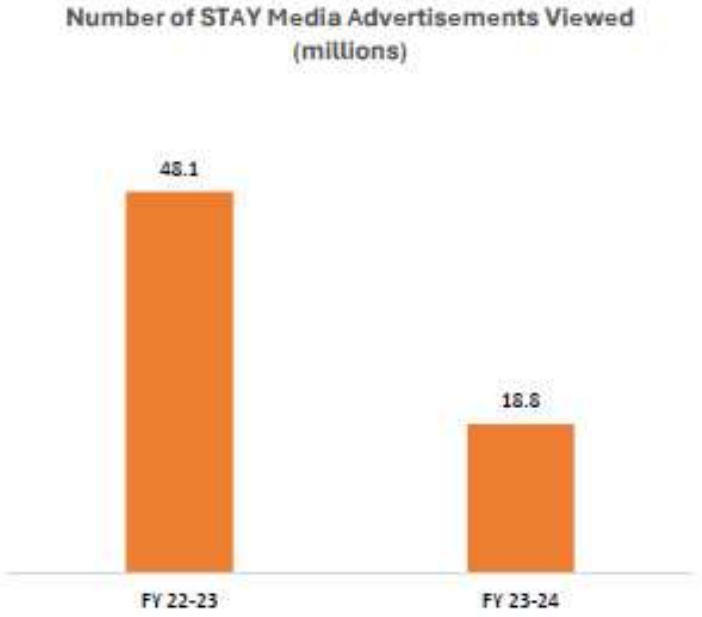
STAY MEDIA CAMPAIGN

Location-based media provided the most exposure over the course of the two-year STAY Media Campaign. Radio continues to be the most strategic method in terms of reaching the Ventura County Spanish-speaking population. STAY radio spots were also run in Mixteco, Zapoteco, and Purépecha. Digital media targeting became an increasingly important media tactic as the STAY campaign continued to run over the course of two years.



[†]May include duplicate viewers who saw multiple campaigns or viewed the advertisements on screen more than once. The estimated number of people viewing ads is unavailable for all digital media channels.
[‡]STAY Media Campaign launched FY 22-23.

VENTURA COUNTY
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WELLNESS EVERYDAY

Conclusion and Recommendations

The Wellness Everyday program has successfully implemented universal prevention messaging regarding mental health throughout Ventura County, utilizing both traditional and digital media channels. The program's bilingual website, Wellness Everyday/Salud Siempre, is a vital resource for individuals seeking educational information about mental health and wellness, suicide prevention, and local support services. The STAY Media Campaign also effectively raises awareness and connects individuals to essential resources. The increase in website users and overall engagement with advertisements demonstrates the program's commitment to reaching a broad audience and promoting mental health awareness in the community.

The data indicate positive engagement trends, with a substantial rise in website traffic and user sessions over the past fiscal years. The targeted outreach strategies, including digital advertisements and location-based messaging, have enhanced visibility and accessibility for both English and Spanish-speaking populations. This success reflects the program's ability to adapt to the community's needs and provide valuable mental health resources.

VENTURA COUNTY BEHAVIORAL HEALTH
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EARLY INTERVENTION

The purpose of the Early Intervention component of MHSA is to intervene early in the emergence of symptoms of mental illness to reduce negative outcomes and foster positive recovery and functional outcomes. Ventura County funds four Early Intervention programs that provide crisis stabilization, family support, group and individual therapy, assessment and screening, educational and vocational services, and outreach and education, including the Early Intervention Network Expansion Grants. These Early Intervention services promote wellness, foster health, and prevent suffering that can result from untreated mental illness. Early Intervention programs may include services to family and caregivers of the person with early onset of a mental illness. A total of 1,954 individuals were served by Early Intervention programs in FYS 2021-2022, 2022–2023, and 2023-2024.

Early Intervention Program Descriptions

COMPASS: A short-term residential program for youth ages 12 to 17 transferring from the Crisis Stabilization Unit. Services include individual and family therapy, case management, psychiatric care, medication support and assessment to assist youth and their caregivers in gaining the stability and skills needed to safely return to the community.

Network Expansion Grants – Early Intervention: Four grantees were provided with financial support to time-limited, community-based projects or programs using innovative strategies to support early recovery and functioning among underrepresented populations experiencing mental illness.

Primary Care Program: Provides assessment, individual and group therapy, case management, and care coordination between primary health and behavioral health providers.

Ventura County Power Over Psychosis (VCPOP, formerly EDIPP): Conducts community outreach and education to community members about early warning signs of psychosis; provides a two-year intervention program with services and supports including psychiatric assessment, medication management, individual therapy, educational/vocational services, case management, multi-family groups, and peer skill-building groups.

Program Highlights

Individuals received core program services†:

FY 21-22: 664
FY 22-23: 634
FY 23-24: 656

1,954

VENTURA COUNTY
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Early Intervention Programs: Demographics of Participants

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Race*	**n = 584**	**n = 557**	**n = 491**
American Indian/Alaska Native	0%	0%	1%
Asian	1%	1%	1%
Black/African American	2%	1%	3%
Hispanic/Latino	--	--	17%
Native Hawaiian, other Pacific Islander	0%	<1%	0%
White	72%	67%	44%
More Than One Race	1%	1%	3%
Other	25%	29%	32%
Declined to answer:	*35*	*24*	*154*
Ethnicity*	**n = 227**	**n = 186**	**n = 258**
Hispanic/Latino	**74%**	**99%**	**88%**
Caribbean	0%	0%	0%
Central American	0%	0%	0%
Mexican/Mex.-Am./Chicano	42%	58%	65%
Puerto Rican	1%	1%	6%
South American	0%	0%	0%
Other Hispanic/Latino	32%	40%	17%
Non-Hispanic/Latino	**26%**	**2%**	**16%**
African	0%	0%	3%
Asian Indian/South Asian	0%	1%	0%
Cambodian	0%	0%	0%
Chinese	0%	0%	0%
Eastern European	0%	0%	0%
European	0%	0%	3%
Filipino	1%	1%	0%
Japanese	0%	0%	0%
Korean	0%	0%	0%
Middle Eastern	0%	0%	0%
Vietnamese	0%	0%	0%
Other Non-Hispanic/Latino	25%	1%	11%
More than one	**0%**	**0%**	**0%**
Declined to answer:	*106*	*1*	*188*

VENTURA COUNTY BEHAVIORAL HEALTH
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Early Intervention Programs: Demographics of Participants

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Primary Language*	**n = 660**	**n = 661**	**n = 638**
English	56%	58%	78%
Spanish	37%	40%	28%
Indigenous	3%	2%	2%
Other	4%	<1%	0%
Declined to answer:	*0*	*0*	*9*
Age Groups	**n = 265**	**n = 286**	**n = 651**
0-15 years	3%	4%	23%
16-25 years	97%	96%	64%
26-59 years	0%	0%	27%
60+ years	0%	0%	2%
Declined to answer:	*14*	*0*	*0*
Gender Identity	**n = 153**	**n = 436**	**n = 433†**
Female	88%	61%	66%
Male	12%	39%	33%
Transgender	0%	<1%	1%
Genderqueer	0%	0%	0%
Questioning or Unsure	0%	0%	0%
Another Gender Identity	0%	0%	0%
Declined to answer:	*1*	*0*	*195*
Sex Assigned at Birth	**n = 662**	**n = 348**	**n = 375**
Male	35%	26%	33%
Female	65%	74%	67%
Declined to answer:	*7*	*0*	*0*
Sexual Orientation*	**n = 274**	**n = 299**	**n = 285†**
Heterosexual or Straight	97%	91%	88%
Bisexual	1%	3%	3%
Gay or Lesbian	2%	2%	1%
Queer	0%	0%	0%
Questioning or Unsure	0%	4%	1%
Another Sexual Orientation	0%	0%	7%
Declined to answer:	*1*	*36*	*326*

†Assigned sex was not reported for COMPASS and VCPOP.
*Percentages may exceed 100% because participants could choose multiple response options.
^Percentages and counts reflect the number of individuals who selected each Hispanic or non-Hispanic ethnicity.
* In FY23-24, Gender Identity and Sexual Orientation were not reported for COMPASS

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Early Intervention Programs: Demographics of Participants

City of Residence	n = 936	n = 724	n = 1228
Camarillo	4%	3%	3%
Fillmore	17%	20%	22%
Moorpark	2%	1%	0%
Newbury Park	1%	1%	0%
Oak Park	0%	<1%	0%
Ojai	1%	1%	3%
Oxnard	22%	25%	25%
Piru	1%	1%	1%
Port Hueneme	2%	2%	2%
Santa Paula	35%	33%	25%
Simi Valley	3%	2%	2%
Thousand Oaks	2%	2%	2%
Ventura	10%	8%	11%
Other	1%	<1%	4%

VENTURA COUNTY
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COMPASS
Seneca Family of Agencies

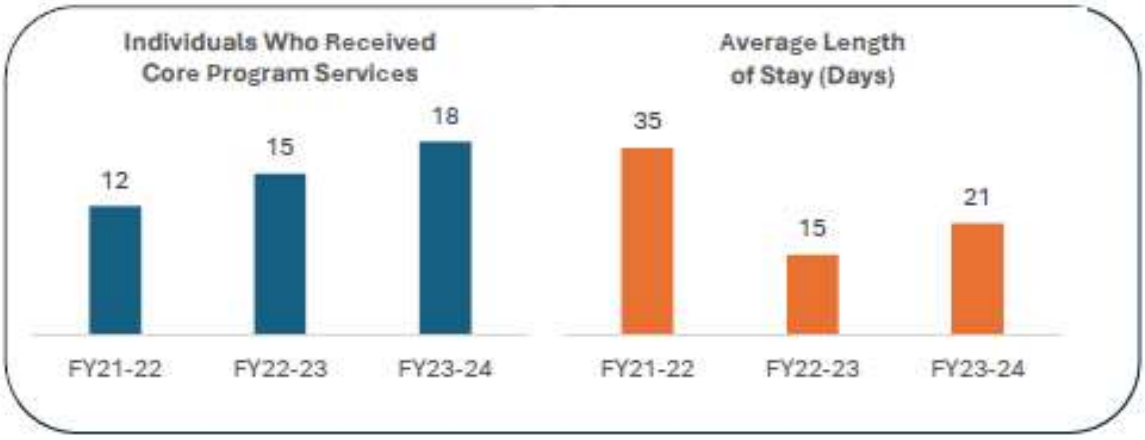
Comprehensive Assessment and Stabilization Services (COMPASS) is a short-term residential program offered as part of the continuum of care for youth ages 12 to 17 transferring from the Crisis Stabilization Unit and Ventura County Behavioral Health clinics. This program provides comprehensive clinical services to assist youth and their caregivers in gaining the stability and skills needed to safely return to the community. Services include individual and family therapy, case management, psychiatric care, medication support, and assessment. The goals of the program are to provide safety and containment while identifying the determinants of the current crisis, assist youth and caregivers in the development of alternative skills and replacement behaviors, create comprehensive aftercare plans that include community linkages, and provide in-depth evaluations that will guide treatment and/or placement decisions along with long-term treatment recommendations. A psychiatrist or tele-psychiatrist is on call 24/7.

Program Strategies

Increases access and linkage to treatment for youth with severe mental illness by stabilizing those in crisis and providing mental health care.

Improves timely access to services for underserved populations by focusing on youth in an essential window of time to prevent and intervene in mental illness.

Program Highlights



VENTURA COUNTY BEHAVIORAL HEALTH
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COMPASS

Demographic Data

COMPASS collects unduplicated demographic data from the individuals it serves. The demographic data in this section represent 45 individuals whose information was entered into VCBH's Electronic Health System (EHR) over the past three years. The EHR system changed in FY23-24 and collected some information differently than in prior years. Demographic data was not collected for disabilities.

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Race*	n = 12*	n = 15	n = 17
American Indian/Alaska Native	0%	0%	0%
Asian	17%	0%	0%
Black/African American	0%	7%	0%
Native Hawaiian, other Pacific Islander	0%	0%	0%
White	58%	47%	35%
More Than One Race	0%	0%	0%
Other	25%	53%	65%
Ethnicity*	n = 11	n = 15	n = 16
Hispanic/Latino			
Caribbean	-	-	-
Central American	-	-	-
Cuban		-	0%
Mexican/Mex.-Am./Chicano	27%	27%	50%
Puerto Rican	0%	0%	13%
South American	-	-	-
Other Hispanic/Latino	0%	33%	19%
Non-Hispanic/Latino			
African	-	-	-
Asian Indian/South Asian	-	-	-
Cambodian	-	-	-
Chinese	-	-	-
Eastern European	-	-	-
European	-	-	-
Filipino	-	-	-
Japanese	-	-	-
Korean	-	-	-
Middle Eastern	-	-	-
Vietnamese	-	-	-
More than one	-	-	-
Other Non-Hispanic/Latino	73%	33%	19%
Primary Language	n = 12	n = 15	n = 18
English	100%	93%	100%
Spanish	0%	7%	0%

VENTURA COUNTY
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COMPASS

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Age Groups	n = 12	n = 15	n = 18
0-15 years	67%	67%	22%
16-25 years	33%	33%	78%
26-59 years	0%	0%	0%
60+ years	0%	0%	0%
Sex Assigned at Birth/Gender Identity**	n = 12	n = 15	n = 18**
Male	8%	20%	22%
Female	92%	80%	78%
Veteran Status	N/A	N/A*	n = 12
Yes	-	-	0%
No	-	-	100%

*Total may exceed 100% because participants could choose multiple response options.

* Small sample sizes can make results less reliable and more affected by unusual values, so these findings should be interpreted cautiously.

** In FY21-22 and FY 22-23, only Sex Assigned at Birth was collected, but Gender Identity was not. In FY 23-24, data on Gender Identity was collected, but Sex Assigned at Birth was not.

Note: Hispanic/Latino is not considered a race according to State guidelines, therefore was not provided as an option.

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COMPASS

Program Activities

COMPASS provides program activities, including mental and behavioral health assessments, case management, and long-term plan development. The table below presents a list of activities and the number of times each activity was provided. Activities were not reported for FY 2023-2024.

Activity Type	FY 21-22	FY 22-23	FY 23-24
Assessments/Evaluation	15	25	99
Case Management	29	52	37
Collateral Meetings	57	52	0
Mental Health Evaluation and Management	42	49	0
Individual Therapy	33	111	0
Medication Management	12	11	290
Plan Development	30	31	38
Psychotherapy	127	31	206
Rehab Service	431	936	1,135
Other*	-	-	206
Total Activities	776	1,298	2,011

*Other included Office or Other Outpatient Visit of New Patient; Medical Team Conference, Participation by Non-Physician, FTF with Patient and/or Family; Medical Team Conference, Participation by Non-Physician. Patient and/or Fam Not Present, Medical Team Conference, Participation by Physician, Patient and/or Family Not Present; Office or Other Outpatient Visit of an Established Patient; Prolonged Office or Other Outpatient EM Service(s) beyond the Maximum Time

VENTURA COUNTY
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COMPASS

Conclusions and Recommendations

The COMPASS program has effectively served as a critical bridge for youth transitioning from crisis care to community re-entry, offering a safe, structured environment with targeted clinical support for youth ages 12 to 17. Over the past three years, COMPASS has provided a wide range of services, including individual and family therapy, psychiatric care, and medication management, all designed to address the immediate crisis and support long-term stabilization. Service provision increased substantially from FY 21-22 to FY 23-24, with activities such as rehabilitation services and psychotherapy experiencing a marked rise, reflecting the program's adaptability to meet client needs with both frequency and depth of care.

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NETWORK EXPANSION GRANTS PROGRAM
EARLY INTERVENTION PROGRAMS

The Network Expansion Grants Program (NEGP) are time-limited, community-based projects or programs promoting wellness among Ventura County residents held between May 2023 and June 2024. NEGPs utilized unconventional strategies for early intervention, providing services that supported early recovery and functioning among underrepresented populations experiencing mental illness.

Program Criteria

New projects/programs supporting un- and underserved populations or regions with prevalent health disparities

Application of new, peer-based approaches to community wellness including:

3) meaningful input from community members in project/program development
4) promotion of individual empowerment, resiliency, and self-determination for participants

Program Highlights

4 grants awarded (and 1 incomplete)

61 individuals engaged in program activities

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NETWORK EXPANSION GRANTS PROGRAM
EARLY INTERVENTION PROGRAMS

Overview of NEGP Grantees

Four NEGPs provided early intervention services to address mental health issues at their onset. One NEGP grant was not completed. Below is a summary of each NEGP early intervention grantee.

Candela Group conducted a Mental Health Workshop Series which provided workshops over ten weeks among family members and/or individuals affected by serious mental illness. The program was offered both in-person and virtually to accommodate the needs of the community members. Each week the participants were introduced to, guided through, and encouraged to share their experiences on a particular topic. A client reference binder was also built throughout the weeks and remained with the participant to be updated and referred to when engaging with service providers.

Mesa Yoga developed a pilot program, Empowering At-Risk Young Adults through Trauma-Informed Therapeutic Yoga (Yoga Therapy). The program goal was for participants to improve self-regulatory behavior and enhance overall well-being while reducing adverse health outcomes. The program was offered free of charge and targeted young adults ages 18-24 who were at risk of declining well-being.

Nate's Place, A Wellness and Recovery Center implemented a new pilot program called Nate's Place that targeted low-to-middle-income teens and young adults who may have been experiencing mental health conditions and/or experiencing a substance abuse disorder. At least 80% of the program participants was from the Latino, BIPOC, and LGBTQ+ communities. It included 1:1 peer support recovery coaching and group outdoor activities such as hiking, rock climbing, boating, fishing, outdoor meditation, yoga, and other excursions led by peer coaches and specialists.

VC Family Justice Center Foundation developed Pathways of Hope, an equine-assisted psychotherapy program that helped youth ages 7-17 focus on their emotions and learn about wellness. All exercises were conducted on the ground and involved interacting with the horses through a variety of activities. The program targeted youth exposed to traumas, including domestic violence and sexual assault, and whose household income was less than $13,000 per year. By exploring and processing patterns externally through activities with horses, children learned to describe their emotions accurately, identify and correct their distortions, and develop more positive coping strategies to enhance their general functioning. These activities could promote change in thinking, which promotes behavior change.

National Health Foundation (Fiscal Agent for FIND – Friend in Deed) (grant incomplete) was a program that intended to offer three support groups and target those who were 1) personally considering or have considered issues related to death by suicide; 2) parenting while dealing with their own mild to moderate mental health challenges; and 3) any community member who was curious to learn about alternative frameworks for supporting people with distressing behaviors or thoughts.

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NETWORK EXPANSION GRANTS PROGRAM
EARLY INTERVENTION PROGRAMS

Demographic Data

Below is demographic information for individuals who received NEGP early intervention services over the past two years. All programs finished in FY 23-24.

Demographic Category	FY 23-24†
Race*	**n = 50**
American Indian/Alaska Native	2%
Asian	2%
Black/African American	6%
Hispanic/Latino	67%
Native Hawaiian, other Pacific Islander	0%
White	12%
More Than One Race	10%
Another Race	2%
Hispanic/Latino Ethnicity	**n = 37**
Mexican/Mexican American/Chicano	95%
Central American	0%
Puerto Rican	0%
South American	0%
Another Hispanic/Latino ethnicity	5%
Non-Hispanic/Latino Ethnicity	**n = 2**
Asian Indian/South Asian	0%
European	50%
Eastern European	0%
African	50%
Filipino	0%
Middle Eastern	0%
Another non-Hispanic/Latino ethnicity	0%
Primary Language*	**n = 52**
English	83%
Spanish	38%
Indigenous	0%
Another Language	0%
Age Groups	**n = 56**
0-15 years	61%
16-25 years	30%
26-45 years	2%
46-59 years	2%
60+ years	5%

VENTURA COUNTY BEHAVIORAL HEALTH
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NETWORK EXPANSION GRANTS PROGRAM
EARLY INTERVENTION PROGRAMS

Demographic Category	FY 23-24[1]
Gender Identity	**n = 51**
Female	47%
Male	53%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%
Sex Assigned at Birth	**n = 52**
Female	48%
Male	52%
Sexual Orientation	**n = 35**
Heterosexual or Straight	89%
Bisexual	0%
Gay or Lesbian	0%
Queer	0%
Questioning or unsure of sexual orientation	0%
Another sexual orientation	11%
Disability	**n = 49**
Yes	16%
No	84%
Disability Type*	**n = 8**
Difficulty seeing	50%
Difficulty hearing, or having speech understood	25%
Another communication disability	13%
Learning disability	38%
Developmental disability	25%
Dementia	13%
Another mental disability, not related to mental illness	0%
Physical/mobility disability	25%
Chronic health condition/chronic pain	25%
Another disability	13%
Veteran	**n = 46**
Yes	0%
No	100%

[1]Candela Group, Nate's Place and VC Family Justice reported demographic data.

*Total may exceed 100% because participants could choose multiple response options.

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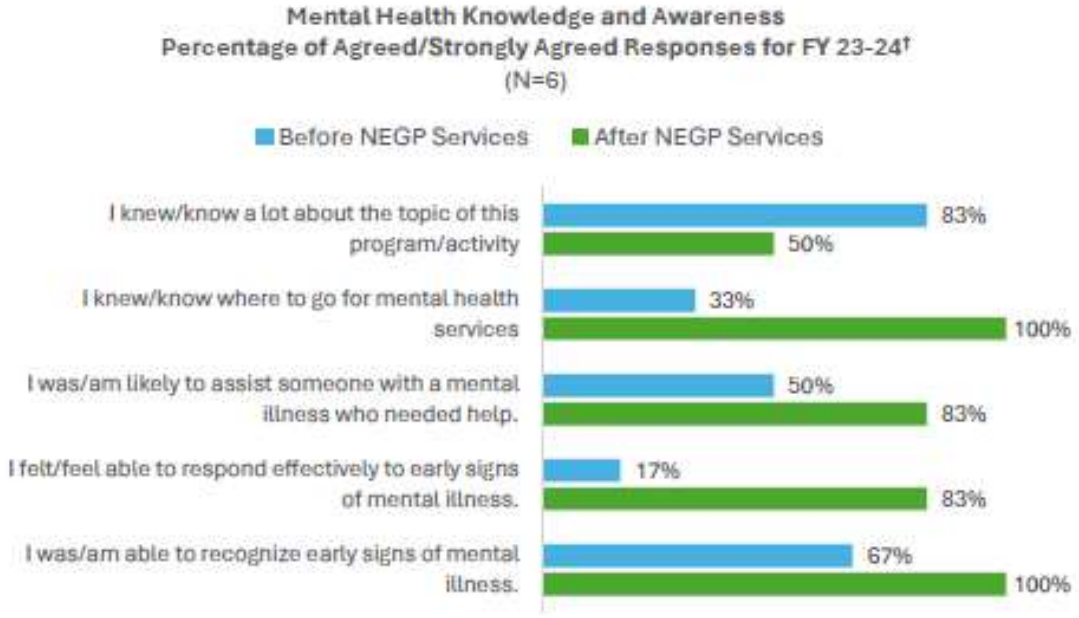
NETWORK EXPANSION GRANTS PROGRAM
EARLY INTERVENTION PROGRAMS

Program Outcomes

All NEGP early intervention grantees reported program outcomes, though specific outcomes varied according to the services provided and activities conducted. Respondents were asked to self-assess their knowledge from a retrospective pre/post perspective, comparing their knowledge before and after receiving services. They rated their level of agreement with various statements related to mental health knowledge and awareness. The chart below displays the percentage of respondents who agreed or strongly agreed with each statement.



†Candela Group collected mental health awareness and knowledge data.

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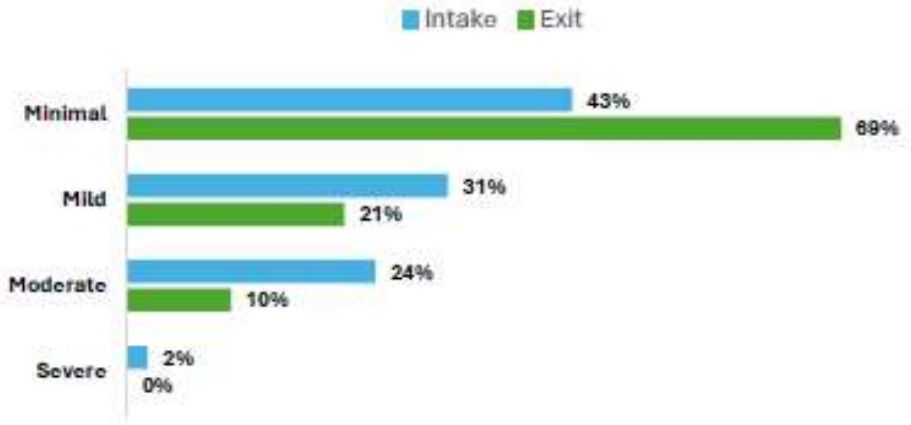
NETWORK EXPANSION GRANTS PROGRAM
EARLY INTERVENTION PROGRAMS

Program Outcomes

NEGPs also assessed respondents' psychological health at two points (intake and exit) using the 10-item Schwartz Outcome Scale (SOS-10). Higher scores on this measure indicate greater psychological well-being and lower levels of distress. The chart below compares intake and exit scores.

Categorization of SOS-10 Scores* Before and After NEGP Services for FY 23-24†*

(n1 = 42, n2 = 39)



†SOS-10 data collected by Nate's Place and VC Family Justice

*Total score on the SOS-10 ranges from 0–60 and scores are categorized as minimal (40–60), mild (33–39), moderate (23–32), or severe (0–22) levels of distress.

Average SOS-10 scores went from 39.1 at intake to 46.5 at exit, indicating improved psychological well-being and reduced levels of distress.

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NETWORK EXPANSION GRANTS PROGRAM
EARLY INTERVENTION PROGRAMS

Program Outcomes

NEGP grantee Mesa Yoga assessed respondents' emotional regulation, quality of life, and overall well-being before and after program services using the following three scales:

1. Quality of Life Scale (QOLS): This scale measures the quality of life through five domains: material and physical well-being, relationships with other people, social, community, and civic activities, personal development and fulfillment, and recreation. Scores can range from 16 to 112, with higher scores indicating better quality of life.
2. Difficulties in Emotional Regulation Scale (DERS): Measures non-acceptance of emotional responses, difficulty engaging in goal-directed behavior, impulse control difficulties, lack of emotional awareness, limited access to emotion regulation strategies, and lack of emotional clarity. Scores can range from 36 to 180, with lower scores indicating better emotional regulation.
3. Spann-Fischer Codependency Scale (SPANN): Measures codependency as "a dysfunctional pattern of relating to others with an extreme focus outside of oneself, lack of expression of feelings, and personal meaning derived from relationships with others." Scores range from 16 to 96, with lower scores indicating less codependency.

The table below compares average test scores and the variability of these scores across respondents.

Before and After: Program Scores for Emotional Regulation, Quality of Life, and Well-being at Mesa Yoga

	QOL (n=6)	DERS (n=6)	SPANN (n=6)
Before Servies	78 ± 4.2	102.8 ± 12.2	58.3 ± 6.3
After Services	93.5 ± 2.1	60.3 ± 9.1	40.5 ± 5.5

QOL, DERS, and SPANN all showed notable improvement after services.

VENTURA COUNTY BEHAVIORAL HEALTH
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NETWORK EXPANSION GRANTS PROGRAM EARLY INTERVENTION PROGRAMS

Program Satisfaction

Respondents were asked to indicate how much they disagreed or agreed with several statements about the program/activity to measure their satisfaction with the NEGP early intervention services they received. The number of respondents who agreed or strongly agreed with each statement is shown in the chart below.

Feedback on Program Effectiveness†
Percentage of Agree/Strongly Agree Responses for Key Statements
(n=5-45)

†Program effectiveness data collected by Candela Group, Nate's Place, and VC Family Justice
*Data not collected by Candela Group.

Virtually all participants were completely satisfied with NEGP services and staff.

VENTURA COUNTY
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NETWORK EXPANSION GRANTS PROGRAM
EARLY INTERVENTION PROGRAMS

Areas of Support

NEGP respondents were asked to select areas where they needed additional support from a list of nine options. The chart below displays the top Areas of Need and the percentage of respondents who indicated they needed help in each area. These insights can guide providers in enhancing services for the upcoming fiscal year.

*Candela Group, Nate's Place and VC Family Justice reported Area of Support data.

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NETWORK EXPANSION GRANTS PROGRAM
EARLY INTERVENTION PROGRAMS

Program Feedback

Respondents who received services from NEGP early intervention programs provided additional feedback through two open-ended questions. Comments were organized by theme for each grantee, with theme descriptions shown in the table below.

NEGP Grantee	Most Helpful About Program	Program Improvements
Candela Group	• Provided information on local resources and advocacy opportunities in Ventura County. • Fostered camaraderie and shared understanding among participants. • Offered a comprehensive list of resources and connections to leadership and support systems.	• Expand reach by recording classes for online access. • Integrate mental health talks and promote community outreach.
Nate's Place	• Deep appreciation for staff's emotional support and kindness. • Staff's genuine care fostered personal growth and helped overcome barriers. • Encouraged exploration of new hobbies and coping mechanisms, reducing isolation.	• More recreational options like fishing and surfing on weekends. • Incorporate educational support, such as tutoring sessions.
VC Family Justice Center	• Supportive and caring staff fostered a sense of appreciation and community. • Engaging in activities with animals (horses, goats) promoted emotional well-being and stress relief. • Opportunities for personal growth through learning coping strategies and socializing.	• Overall satisfaction with the program • Requests for more time with horses and opportunities for riding. • Interest in introducing different animals.

*Mesa Yoga did not collect program feedback data.

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NETWORK EXPANSION GRANTS PROGRAM
EARLY INTERVENTION PROGRAMS

Conclusions and Recommendations

The Network Expansion Grants Program (NEGP) has effectively promoted mental wellness among Ventura County's underrepresented populations through innovative, community-based interventions. Program services were primarily provided to Hispanic/Latino youth (81% were 25 or younger), reflecting a solid alignment with the county's demographic needs. These programs contributed positively to respondents' mental health knowledge, psychological well-being, and overall coping strategies, evidenced by self-assessments and positive open-text feedback.

Given the reported positive outcomes, extending program reach and services could benefit these vulnerable populations. Recommendations include exploring options for recording sessions, as suggested by the Candela Group, to improve accessibility and continuity of services. Similarly, expanding recreational and therapeutic activities, such as those requested by participants at Nate's Place and VC Family Justice Center, could deepen program engagement and foster a greater sense of community and personal growth. By building on these successes, the NEGP can continue to support the mental health and wellness of Ventura County's diverse residents.

VENTURA COUNTY
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PRIMARY CARE PROGRAM
Clinicas del Camino Real, Inc.

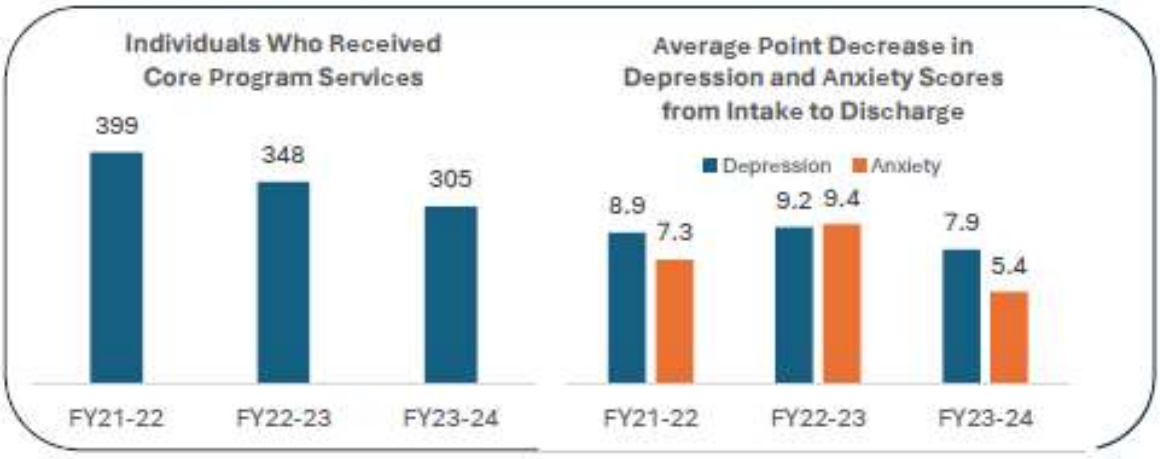
Primary Care Program provides assessment, individual and group therapy, case management, and care coordination between primary health and behavioral health providers. Primary Care Program works with clients ages 12 and older who may be experiencing depression and/or anxiety and is able to refer them to appropriate mental health services in a timely manner. They can also provide immediate interventions to reduce clients' risks of developing other severe mental health conditions. Additionally, the program provides evidence-based services to individuals who would otherwise not have access by delivering services at multiple locations throughout Ventura County, with the goal of increasing service access to underserved populations including those who do not have reliable transportation.

Program Strategies

Improves timely access to services for underserved populations by providing social and emotional support and connections to mental health care to LGBTQ+ youth.

Implements non-stigmatizing and non-discriminatory practices by providing LGBTQ+ cultural competency trainings to potential responders and agency staff.

Program Highlights‡



‡ This program made community referrals, which were not included in the data collection.

VENTURA COUNTY BEHAVIORAL HEALTH
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PRIMARY CARE PROGRAM

Demographic Data

The Primary Care Program collects unduplicated demographic data from the individuals it serves and trains. Of the 1,052 individuals who received core program services over the past three years, the majority completed a demographic form presented below.

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Race*	n = 327	n = 277	n = 194
American Indian/Alaska Native	0%	0%	0%
Asian	1%	1%	1%
Black/African American	1%	0%	2%
Native Hawaiian, other Pacific Islander	0%	0%	0%
White (includes Hispanic)‡	96%	97%	95%
More Than One Race	1%	2%	3%
Other	0%	0%	0%
Ethnicity	n = 288	n = 247	n = 148
Hispanic/Latino	94%	96%	89%
Non-Hispanic/Latino	6%	4%	11%
Primary Language	n = 399	n = 347	n = 305
English	35%	35%	38%
Spanish	65%	71%	65%
Indigenous	5%	4%	3%
Other	0%	0%	0%
Age Groups	n = 399	n = 348	n = 305
0-18 years	10%	8%	8%
19-60 years	84%	88%	89%
60+ years	6%	4%	3%
Gender Identity	n = 153	n = 150	n = 126
Female	88%	88%	87%
Male	12%	12%	13%
Transgender	0%	0%	0%
Genderqueer	0%	0%	0%
Questioning or Unsure	0%	0%	0%
Another Gender Identity	0%	0%	0%
Sex Assigned at Birth	n = 398	n = 348	n = 305
Male	24%	26%	25%
Female	76%	74%	75%

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PRIMARY CARE PROGRAM

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Sexual Orientation	n = 278	n = 276	n = 232
Heterosexual or Straight	96%	93%	92%
Bisexual	1%	1%	3%
Gay or Lesbian	2%	2%	3%
Queer	0%	0%	0%
Questioning or Unsure	1%	4%	2%
Another Sexual Orientation	0%	0%	0%
Veteran Status	n=396	n=344	n=303
Veteran	<1%	<1%	1%

*Total may exceed 100% because participants could choose multiple response options.

‡ Data reported in the 'White' racial category also includes individuals identifying as 'Hispanic.'

VENTURA COUNTY
BEHAVIORAL HEALTH
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PRIMARY CARE PROGRAM

Program Activities

Primary Care Program provides program activities, including assessment, individual therapy, and case management. The table below lists activities and the number of individuals who received them over the past three years.

Activity Type	FY 21-22	FY 22-23	FY 23-24
Case Management: Face to Face	18	11	11
Case Management: Non-Face to Face	59	16	10
Individual Therapy	1,125	1,248	1,072
Individual Therapy – 30 Minutes	307	89	99
Initial Assessment	218	152	133
Initial Assessment: Face to Face	22	12	10
Initial Assessment: Non-Face to Face	10	5	7
Total Activities	1,759	1,533	1,342

VENTURA COUNTY
BEHAVIORAL HEALTH
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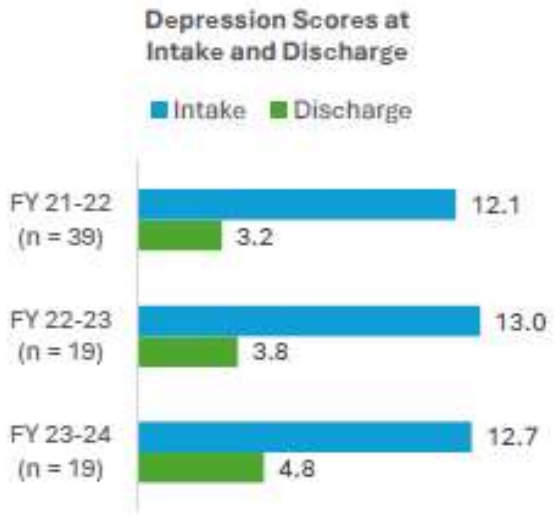
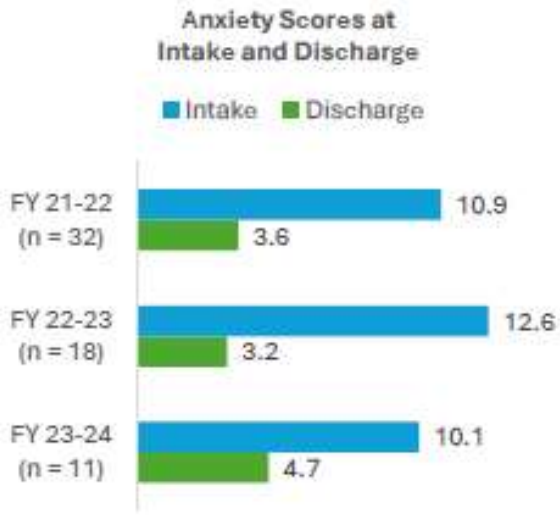
PRIMARY CARE PROGRAM

Program Outcomes

Primary Care Program tracks outcomes using the Patient Health Questionnaire (PHQ-9) and Generalized Anxiety Disorder Scale (GAD-7) as measures of depression and generalized anxiety, respectively. Average scores across participants at intake and discharge are summarized below for patients discharged from services over the past three years.





Each year:

Each year at intake, average PHQ-9 scores suggest participants had moderate levels of depression but at discharge, there were minimal to no levels of depression.

On average, participants who were discharged experienced an 8.7-point decrease in depression symptoms from intake to discharge.

Each year at intake, average GAD-7 scores suggest participants had moderate levels of anxiety but at discharge, there were minimal to no levels of anxiety.

On average, participants who were discharged experienced a 7.4-point decrease in anxiety symptoms from intake to discharge.

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PRIMARY CARE PROGRAM

Conclusions and Recommendations

The Primary Care Program has demonstrated effectiveness in providing accessible mental health services for underserved populations in Ventura County, especially those experiencing depression and anxiety. Over the past three years, the program has reached a predominantly Hispanic/Latino population, with services delivered across various locations to improve accessibility, including for individuals with limited transportation options. The program's success is reflected in its capacity to provide immediate, evidence-based interventions that help reduce the risk of severe mental health conditions among clients aged 12 and older. Additionally, the program's ability to offer services in both English and Spanish has been essential in meeting the needs of diverse clients, with Spanish-speaking clients comprising over 65% of participants in recent years.

Outcomes measured through the Patient Health Questionnaire (PHQ-9) and Generalized Anxiety Disorder Scale (GAD-7) highlight the program's impact in reducing depressive and anxiety symptoms among participants by discharge. These improvements suggest that combining individual and group therapy, case management, and care coordination with primary health providers is both timely and effective. The program's strong engagement with Hispanic/Latino populations, especially those with limited access to traditional mental health services, emphasizes its role as a critical safety net for underserved communities.

To strengthen the program's impact, targeted outreach efforts could enhance engagement with underserved groups, such as Indigenous and non-Spanish-speaking populations, who currently represent a smaller portion of those served. Additionally, the program has experienced a decline in total activities, particularly in case management and initial assessments, indicating a need for strategic adjustments to improve service delivery and accessibility. Prioritizing the optimization of case management processes, increasing access to initial assessments, and maintaining resources for individual therapy are recommended to sustain and potentially grow service levels.

VENTURA COUNTY BEHAVIORAL HEALTH
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VENTURA COUNTY POWER OVER PSYCHOSIS (VCPOP)

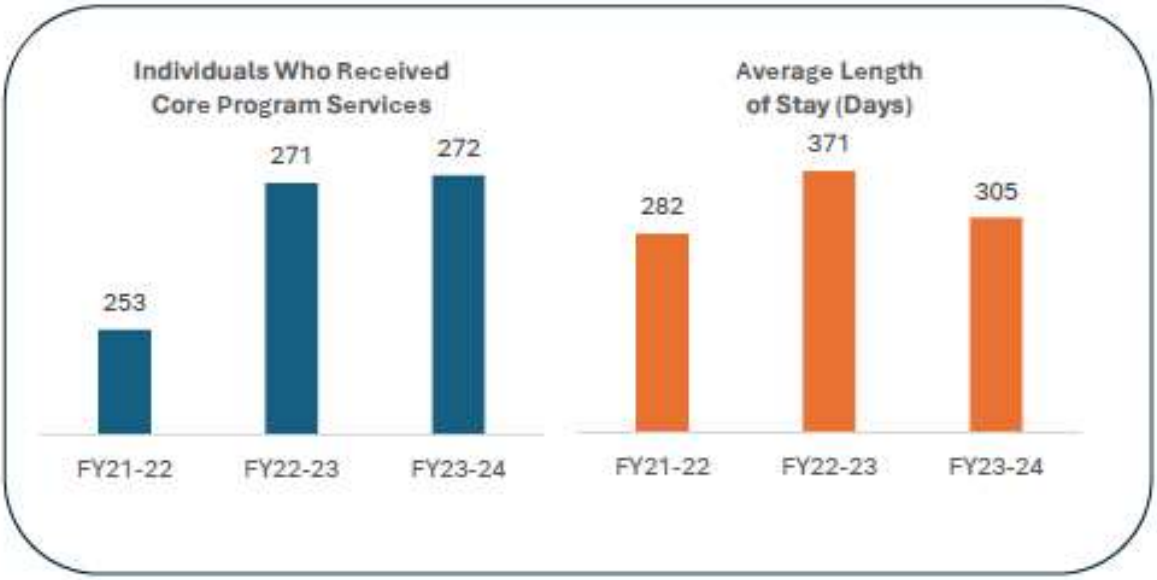
Ventura County Power Over Psychosis conducts community outreach and education to community members about early warning signs of psychosis and provides up to a four-year intervention program with services and supports including psychiatric assessment, medication management, individual therapy, educational/vocational services, case management, multi-family groups, and peer skill-building groups.

Program Strategies

Provides intensive support and education to individuals and their support systems to reduce stress and manage symptoms.

Increases recognition of early signs of psychosis through outreach and trainings to community members including school staff, clinicians, spiritual leaders, and police.

Program Highlights



VENTURA COUNTY BEHAVIORAL HEALTH
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VENTURA COUNTY POWER OVER PSYCHOSIS (VCPOP)

Demographic Data

VCPOP collects unduplicated demographic data from the individuals it serves. The data in this section represent demographic information provided by 796 individuals served over the past three years whose information was entered into VCBH's Electronic Health System (EHR) over the past three years. The EHR system changed in FY23-24 and collected some information differently than in prior years.

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Race*	n = 250	n = 267	n = 230
American Indian/Alaska Native	0%	0%	1%
Asian	1%	3%	1%
Black/African American	4%	3%	3%
Native Hawaiian, other Pacific Islander	0%	0%	1%
White	37%	36%	34%
More Than One Race	0%	0%	0%
Other	58%	58%	60%
Ethnicity*	n = 222	n = 235	n = 55
Hispanic/Latino			
Caribbean	-	-	-
Central American	-	-	-
Mexican/Mex.-Am./Chicano	42%	45%	55%
Puerto Rican	1%	1%	4%
South American	-	-	-
Other Hispanic/Latino	32%	29%	27%
Non-Hispanic/Latino			
African	-	-	-
Asian Indian/South Asian	-	-	-
Cambodian	-	-	-
Chinese	-	-	-
Eastern European	-	-	-
European	-	-	-
Filipino	-	-	-
Japanese	-	-	-
Korean	-	-	-
Middle Eastern	-	-	-
Vietnamese	-	-	-
More than one	-	-	-
Other Non-Hispanic/Latino	25%	25%	15%

VENTURA COUNTY BEHAVIORAL HEALTH
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VENTURA COUNTY POWER OVER PSYCHOSIS (VCPOP)

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Primary Language*	n = 249	n = 267	n = 263
English	94%	93%	90%
Spanish	6%	7%	9%
Other	0%	0%	1%
Age Groups	n = 253	n = 271	n = 272
0-15 years	1%	1%	2%
16-25 years	99%	99%	85%
26-59 years	0%	0%	13%
60+ years	0%	0%	0%
Sex Assigned at Birth/Gender Identity **	n = 253	n = 271	n = 256
Male	54%	56%	53%
Female	46%	44%	46%
Sexual Orientation	n = 30	n = 23	n = 18
Heterosexual or Straight	74%	70%	83%
Bisexual	20%	22%	6%
Gay or Lesbian	3%	4%	0%
Queer	0%	0%	0%
Questioning or Unsure	3%	4%	0%
Another Sexual Orientation	0%	0%	11%

*Total may exceed 100% because participants could choose multiple response options.

** In FY21-22 and FY 22-23, only Sex Assigned at Birth was collected, but Gender Identity was not. In FY 23-24, data on Gender Identity was collected, but Sex Assigned at Birth was not.

Note: Hispanic/Latino is not considered a race, but rather, an ethnicity according to State guidelines, therefore was not provided as an option.

VENTURA COUNTY BEHAVIORAL HEALTH
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VENTURA COUNTY POWER OVER PSYCHOSIS (VCPOP)

Program Activities

Program activities include drop-in programs, trainings and workshops, meetings, and support groups facilitated by VCPOP program staff. Program participants and other community members may participate in these activities and events.

Activity Type	FY 21-22	FY 22-23	FY 23-24
Assessments/Evaluation	28	14	35
Case Management	873	1,010	0
Collateral Meetings	622	844	0
Crisis Intervention	117	176	169
Mental Health Evaluation & Management	440	697	93
Individual/Group Therapy	520	649	640
Intensive Care Coordination	55	67	0
Medication Management	691	916	988
Psychotherapy	588	385	1,963
Plan Development	273	111	401
No-Show/Outreach	1,226	1,592	1010
Paperwork Completion	933	886	0
Rehab	208	560	188
Targeted Case Management	50	1,540	1,733
Transportation/Travel	30	60	0
Whatever It Takes Support	13	8	106
Interpretation	1	1	1
Other*	-	-	4,077
Total Activities	6,668	9,516	11,404

*Other included Behavioral Health Prevention Education Service-Peer; Client Non-Billable Service Must Document; Consult; Medical Team Conference, Participation by Non-Physician. Patient and/or Fam Not Present; Medical Team Conference, Participation by Physician, Patient and/or Family Not Present; Office or Other Outpatient Visit of an Established Patient; Office or Other Outpatient Visit of New Patient; Prolonged Office or Other Outpatient EM Service(s) beyond the Maximum Time; Self-help/peer services; Sign Language or Oral Interpretive Services; Therapeutic, Prophylactic, or Diag Injection-Subcutaneous or Intramuscular, Interactive Complexity, Telephone Assessment and Management Service, and Telephone EM Service.

VENTURA COUNTY
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VENTURA COUNTY POWER OVER PSYCHOSIS (VCPOP)

Conclusions and Recommendations

Ventura County's Power Over Psychosis program has made impressive strides in supporting individuals at risk for psychosis through comprehensive community outreach and robust, multi-faceted support services. The program has shown steady engagement, with an increase in individuals' participation in activities from FY21-22 to FY22-23 and FY23-24. Its focus on early intervention, particularly among young adults aged 16 to 25, aligns with the demographic most vulnerable to early psychosis, while its community training efforts with diverse groups — including school staff, clinicians, and law enforcement — help raise awareness and improve early identification of psychosis. Moreover, the program's commitment to inclusive support is manifest in the predominance of services provided in English and Spanish, addressing linguistic needs within the community, and its culturally attuned outreach efforts are likely to increase accessibility and engagement further.

To enhance program impact, expanding targeted outreach to underrepresented ethnic groups within the community and increasing engagement for younger age groups (0-15 years) could provide early benefits in preventing the progression of psychosis. Additionally, focusing on reducing no-show rates, particularly for essential services such as individual therapy and medication management, may increase program efficiency and participant outcomes. Implementing these strategies will strengthen the program's commitment to early intervention in psychosis and build on its already considerable achievements.

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OTHER PEI PROGRAMS

The programs under Other PEI Programs encompass the core program categories of Outreach for Increasing Recognition of Early Signs of Mental Illness, Access and Linkage to Treatment, and Stigma and Discrimination Reduction, as well as Suicide Prevention (optional) and Improving Timely Access to Services for Underserved Populations (optional) programs. All programs in this section focus primarily on training potential first responders—including educators, students, law enforcement personnel, first responders, people with lived experience, and other community members—about ways to recognize and respond effectively to early signs of mental illness. Programs also seek to combat negative perceptions about misinformation and/or stigma associated with having a mental illness or seeking help for mental illness.

A total of 15,776 individuals were served by Other PEI Programs in FYS 2021-2022, 2022–2023, and 2023-2024. Other PEI Programs include the following program categories:

Outreach for Increasing Recognition of Early Signs of Mental Illness programs train potential responders to recognize and respond effectively to early signs of potentially severe and disabling mental illness.

Access and Linkage to Treatment programs connect individuals with severe mental illness to medical care and treatment as early in the onset of these conditions as practicable. These programs focus on screening, assessment, referral, telephone helplines, and mobile response.

Stigma and Discrimination Reduction programs reduce negative attitudes, beliefs, stereotypes, and discrimination toward those with mental illness or seeking mental health services and increase dignity, inclusion, and equity for individuals with mental illness and their families.

Suicide Prevention programs provide organized activities to prevent suicide because of mental illness.

Other PEI Program Descriptions

Crisis Intervention Team (CIT): Provides training for first responders to assess and assist people in mental health crises compassionately and effectively through de-escalation, reduction of use of force, and collaboration with consumers, families, the community, and other stakeholders.

Diversity Collective: Hosts weekly support groups for LGBTQ+ youth, TAY, and their allies, as well as promotes cultural competency and other mental health trainings to schools and agencies to spread awareness of LGBTQ+ mental health needs.

La CLAve Education and Training: Trains potential Ventura County Behavioral Health (VCBH) staff and community collaborators to deliver an evidence-based workshop designed to help the Latino community in Ventura County recognize symptoms of serious mental illness and support them in accessing early treatment services.

Logrando Bienestar: Helps youth and adults in the Latino community understand the importance of mental and emotional health, with the goal of helping individuals access services for productive and healthy lifestyles.

Network Expansion Grants – Other PEI: Provides financial support to time-limited, community-based projects or programs using novel approaches to reduce stigma and discrimination related to mental illness and seeking mental health support among underrepresented populations.

Rapid Integrated Support & Engagement (RISE): Offers field-based connections to mental health assessment and treatment as well as case management.

VCBH Suicide Prevention: Provides resources to advance awareness and knowledge of suicide and related topics.

Program Highlights

Individuals received core program services†:

FY 21-22: 2,476
FY 22-23: 6,668
FY 23-24: 6,632

15,776

VENTURA COUNTY BEHAVIORAL HEALTH
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Other PEI Programs: Demographics of Participants[8]

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Race*	**n = 2,445**	**n = 2,578**	**n = 1433**
American Indian/Alaska Native	1%	<1%	1%
Asian	1%	1%	3%
Black/African American	2%	1%	2%
Hispanic/Latino	62%	4%	41%
Native Hawaiian, other Pacific Islander	0%	<1%	0%
White	34%	38%	37%
More Than One Race	0%	1%	7%
Other	0%	54%	18%
Declined to answer:	*8*	*8*	*867*
Ethnicity*	**n =**	**n = 1,580**	**n = 1354**
Hispanic/Latino	**81%**	**97%**	**83%**
Caribbean	0%	0%	0%
Central American	0%	1%	5%
Mexican/Mex.-Am./Chicano	57%	73%	69%
Puerto Rican	0%	1%	1%
South American	0%	0%	2%
Other Hispanic/Latino	25%	21%	3%
Non-Hispanic/Latino	**18%**	**3%**	**18%**
African	0%	0%	1%
Asian Indian/South Asian	0%	0%	0%
Cambodian	0%	0%	0%
Chinese	0%	0%	1%
Eastern European	0%	0%	3%
European	1%	1%	8%
Filipino	0%	1%	2%
Japanese	0%	0%	0%
Korean	0%	0%	0%
Middle Eastern	0%	0%	2%
Vietnamese	0%	0%	0%
Other Non-Hispanic/Latino	17%	0%	5%
More than one ethnicity	**0%**	**1%**	**1%**
Declined to answer:	*513*	*11*	*800*

VENTURA COUNTY BEHAVIORAL HEALTH
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Other PEI Programs: Demographics of Participants[§]

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Primary Language*	**n = 2,443**	**n = 2,614**	**n = 2,229**
English	62%	75%	79%
Spanish	35%	24%	30%
Indigenous	1%	1%	1%
More than one language	-	-	8%
Other	2%	<1%	1%
Declined to answer:	*11*	*1*	*73*
Age Groups	**n = 2,424**	**n = 2,657**	**n = 2,325**
0-15 years	50%	37%	16%
16-25 years	17%	22%	25%
26-59 years	29%	34%	49%
60+ years	4%	6%	11%
Declined to answer:	*3*	*0*	*3*
Gender Identity	**n = 1,755**	**n = 1,377**	**n = 1,389**
Female	58%	44%	55%
Male	42%	50%	41%
Transgender	0%	2%	2%
Genderqueer	0%	1%	1%
Questioning or Unsure	0%	3%	1%
Another Gender Identity	0%	1%	1%
Declined to answer:	*4*	*6*	*848*
Sex Assigned at Birth	**n = 944**	**n = 1,565**	**n = 313**
Male	47%	41%	52%
Female	53%	59%	48%
Declined to answer:	*8*	*12*	*4*
Sexual Orientation	**n = 226**	**n = 391**	**n = 455**
Heterosexual or Straight	90%	61%	87%
Bisexual	4%	13%	4%
Gay or Lesbian	3%	10%	4%
Queer	0%	8%	3%
Questioning or Unsure	0%	3%	3%
Another Sexual Orientation	2%	5%	1%
Declined to answer:	*599*	*437*	*1726*

*Percentages may add to or exceed 100% because participants could choose multiple response options.

§ Current gender identity data was not collected from RISE in FY21-22; assigned sex data was not collected from RISE in FY 23-24.

^Percentages and counts reflect the number of individuals who selected each Hispanic or non-Hispanic ethnicity.

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Other PEI Programs: Demographics of Participants[§]

City*	n = 2,154	n = 1,375	n = 1,252
Camarillo	4%	7%	11%
Fillmore	4%	3%	1%
Moorpark	3%	2%	2%
Newbury Park	1%	2%	0%
Oak Park	0%	<1%	0%
Ojai	1%	1%	1%
Oxnard	47%	29%	34%
Piru	1%	<1%	0%
Port Hueneme	3%	3%	1%
Santa Paula	12%	7%	14%
Simi Valley	6%	10%	4%
Thousand Oaks	3%	6%	2%
Ventura	12%	20%	18%
Other	2%	10%	9%

*City of residence data is not available for CIT and Logrando Bienestar for FY23-24.

VENTURA COUNTY
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CRISIS INTERVENTION TEAM
Ventura County Law Enforcement

The Crisis Intervention Team (CIT) is a mental health training program for first responders throughout Ventura County. CIT Academy provides trainings to help first responders assess and assist people in mental health crises compassionately and effectively. The four primary goals of the CIT program are to reduce the intensity of a crisis using de-escalation strategies, reduce the necessity of use-of-force, promote pre-custody diversion, and collaborate with mental health consumers, their families, the community, and other stakeholders to build and support a vibrant and accessible crisis system.

Program Strategies

Provides training to first responders to increase recognition of early signs of mental illness and how to respond to crises effectively.

Implements non-stigmatizing and non-discriminatory practices by providing culturally competent trainings to first responders.

VENTURA COUNTY
BEHAVIORAL HEALTH
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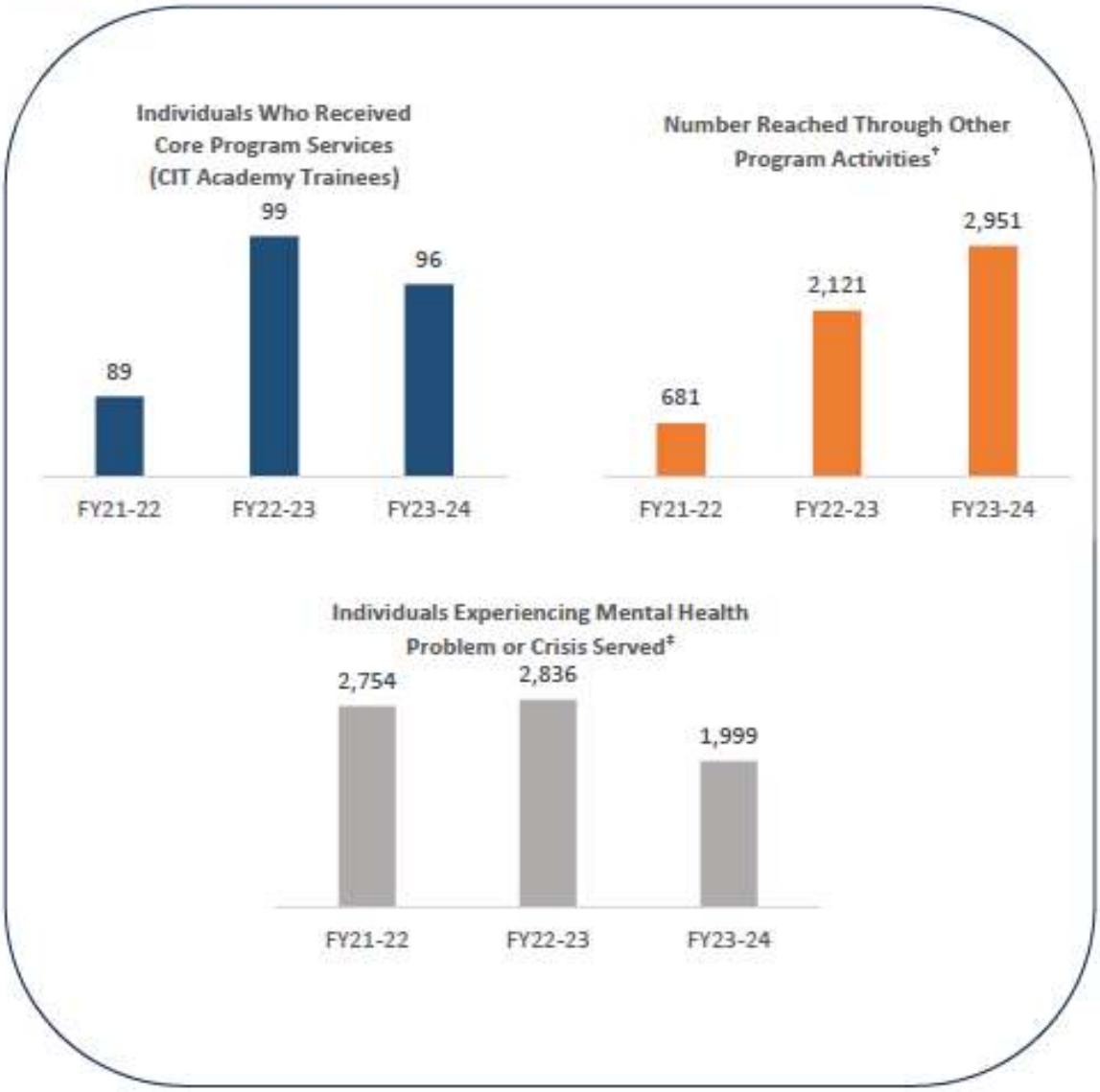
CRISIS INTERVENTION TEAM

Program Highlights‡



‡This program did not provide referrals.

†Number of participants/individuals may be duplicated.

VENTURA COUNTY
BEHAVIORAL HEALTH
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CRISIS INTERVENTION TEAM

Demographic Data

CIT collects unduplicated demographic data from CIT Academy trainees. This section presents information from 256 individuals who completed a demographic form over the past three years.

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Race*	**n = 70**	**n = 76**	**n = 71**
American Indian/Alaska Native	0%	3%	3%
Asian	0%	1%	1%
Black/African American	6%	4%	1%
Hispanic/Latino	0%	-	-
Native Hawaiian, other Pacific Islander	3%	0%	1%
White	75%	72%	86%
More Than One Race	3%	8%	11%
Other	13%	18%	25%
Ethnicity*	**n = 59**	**n = 74**	**n = 91**
Hispanic/Latino			
Caribbean	0%	0%	0%
Central American	0%	1%	7%
Mexican/Mex.-Am./Chicano	45%	58%	49%
Puerto Rican	4%	4%	1%
South American	4%	0%	1%
Other Hispanic/Latino	0%	11%	8%
Non-Hispanic/Latino			
African	5%	1%	1%
Asian Indian/South Asian	0%	1%	0%
Cambodian	0%	0%	1%
Chinese	0%	0%	1%
Eastern European	4%	3%	3%
European	22%	12%	12%
Filipino	0%	3%	2%
Japanese	0%	3%	1%
Korean	0%	0%	0%
Middle Eastern	0%	0%	2%
Vietnamese	0%	0%	0%
More than one	5%	8%	2%
Other Non-Hispanic/Latino	11%	9%	12%

VENTURA COUNTY
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CRISIS INTERVENTION TEAM

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Primary Language*	**n = 71**	**n = 86**	**n = 91**
English	90%	93%	98%
Spanish	3%	3%	9%
Indigenous	-	-	-
More than one language	7%	3%	3%
Age Groups	**n = 71**	**n = 88**	**n = 94**
0-15 years	0%	0%	0%
16-25 years	30%	42%	35%
26-59 years	69%	58%	65%
60+ years	1%	0%	0%
Gender Identity	**n = 71**	**n = 88**	**n = 93**
Female	31%	19%	15%
Male	68%	81%	82%
Transgender	0%	0%	0%
Genderqueer	0%	0%	0%
Questioning or Unsure	1%	0%	3%
Another Gender Identity	0%	0%	0%
Sex Assigned at Birth	**n = 72**	**n = 88**	**n = 92**
Female	32%	19%	15%
Male	68%	81%	85%
Sexual Orientation	**n = 66**	**n = 87**	**n = 92**
Bisexual	2%	1%	1%
Gay or Lesbian	0%	1%	0%
Heterosexual or Straight	98%	98%	99%
Queer	0%	0%	0%
Questioning or Unsure	0%	0%	0%
Another Sexual Orientation	0%	0%	0%
Disability	**n = 73**	**n = 88**	**n = 93**
Yes	4%	0%	1%
No	96%	100%	99%
Veteran Status	**n = 70**	**n = 88**	**n = 92**
Yes	24%	15%	18%
No	76%	85%	82%

*Total may exceed 100% because participants could choose multiple response options.

VENTURA COUNTY BEHAVIORAL HEALTH
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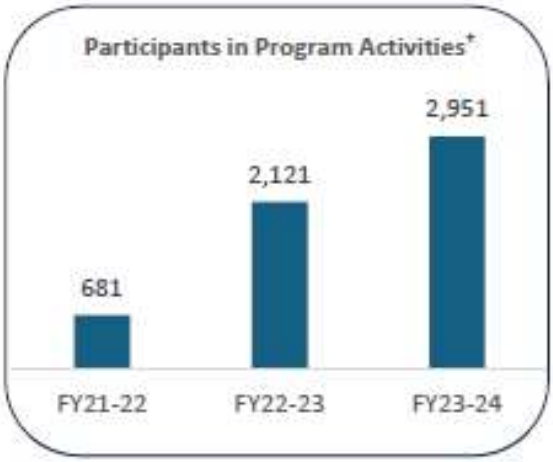
CRISIS INTERVENTION TEAM

Program Activities

In addition to the CIT Academy cohorts, program activities include other trainings and presentations facilitated by program staff. These trainings covered topics such as suicide prevention, early recognition of signs of mental illness, and stigma and discrimination reduction. Participants may include first responder personnel as well as community members.

Activity Type	FY 21-22	FY 22-23	FY 23-24
Presentations	5	15	26
Basic Academy Trainings	6	8	18
Other Law Enforcement Trainings	25	4	39
Program Updates	-	4	6
Total Activities/Events	38	31	89



†Number of participants/individuals may be duplicated.

VENTURA COUNTY
BEHAVIORAL HEALTH
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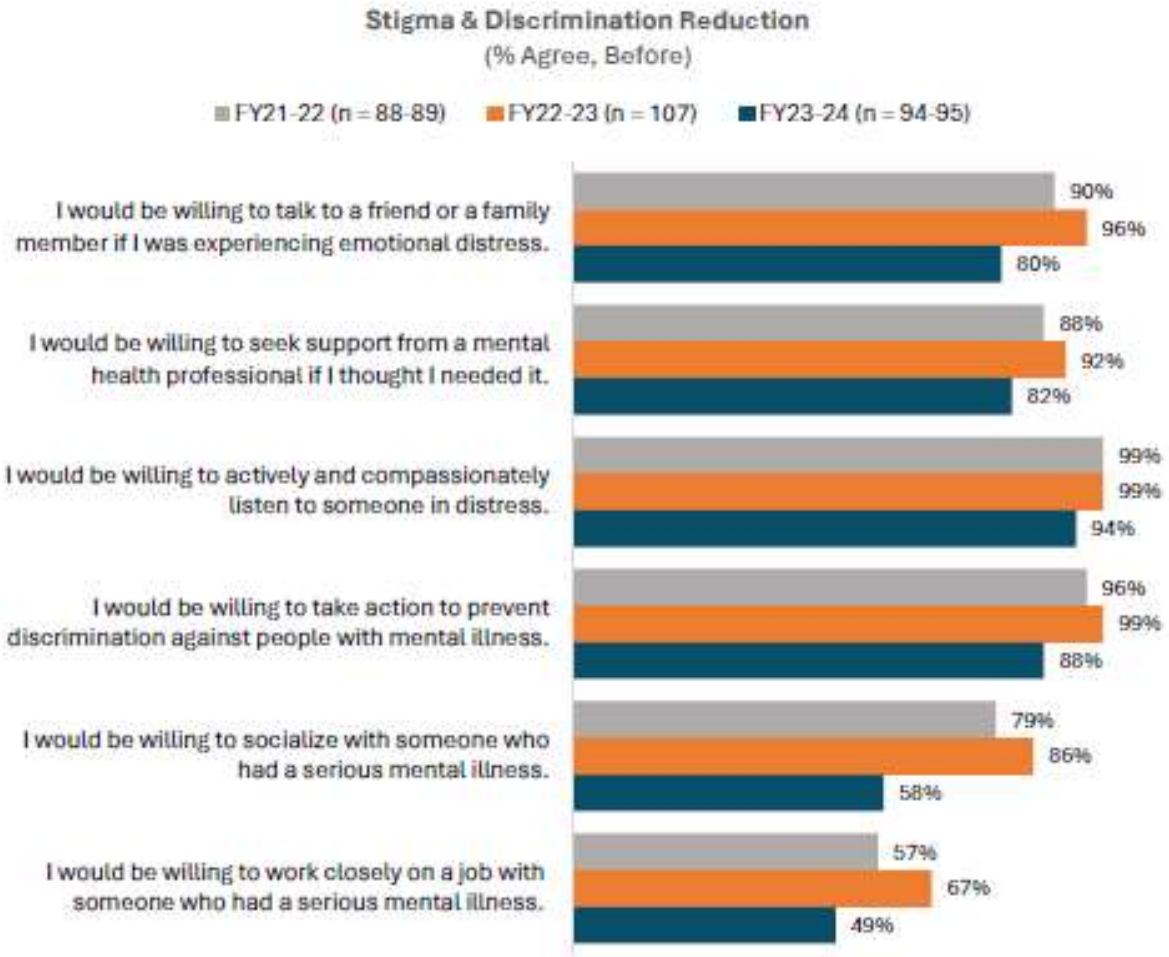
CRISIS INTERVENTION TEAM

Program Outcomes: Training Evaluation Survey

CIT monitors program outcomes by surveying CIT Academy trainees on topics such as stigma, discrimination, and racial bias at two time points: before and after the training. The charts below present results from the past three years of these surveys.



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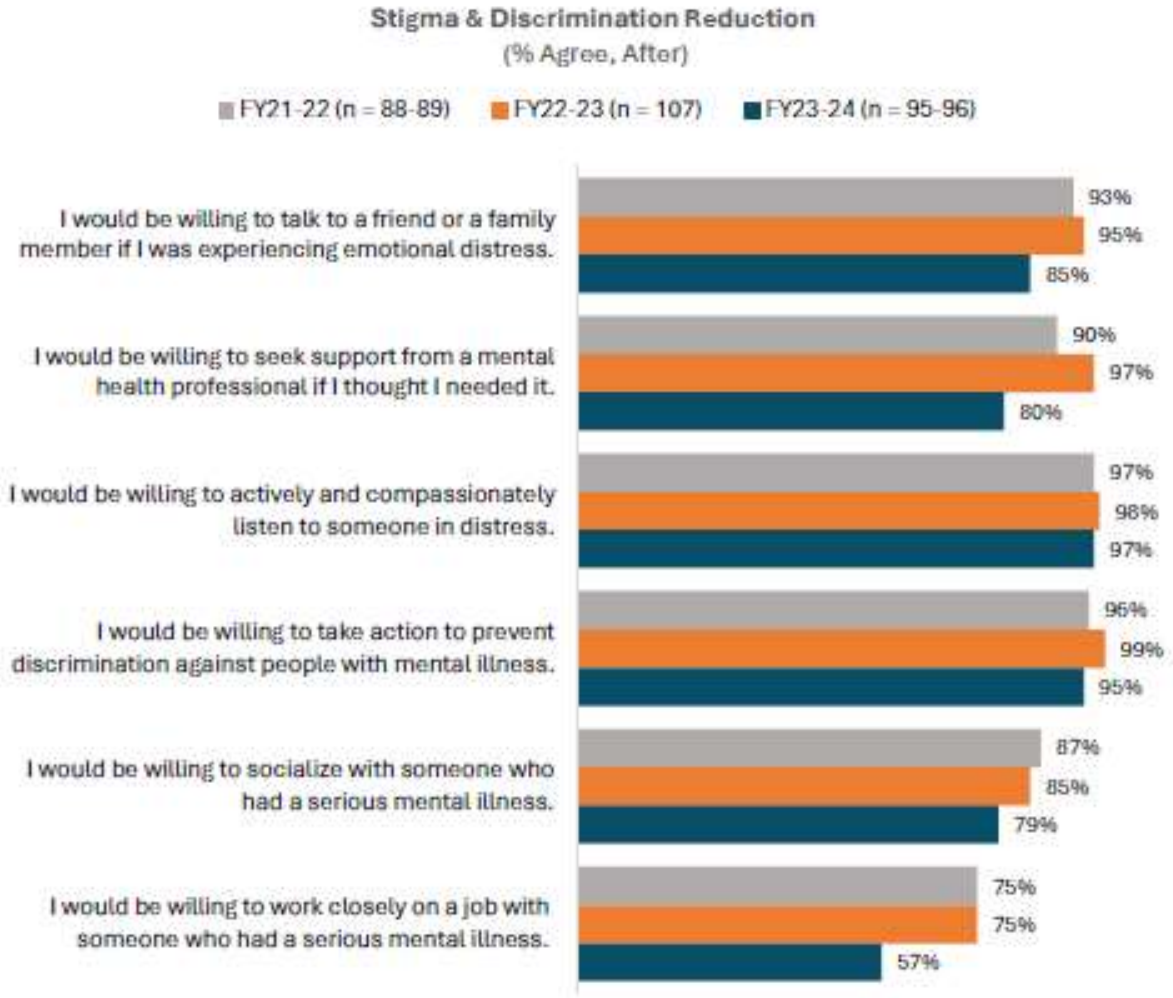
CRISIS INTERVENTION TEAM

Program Outcomes: Training Evaluation Survey



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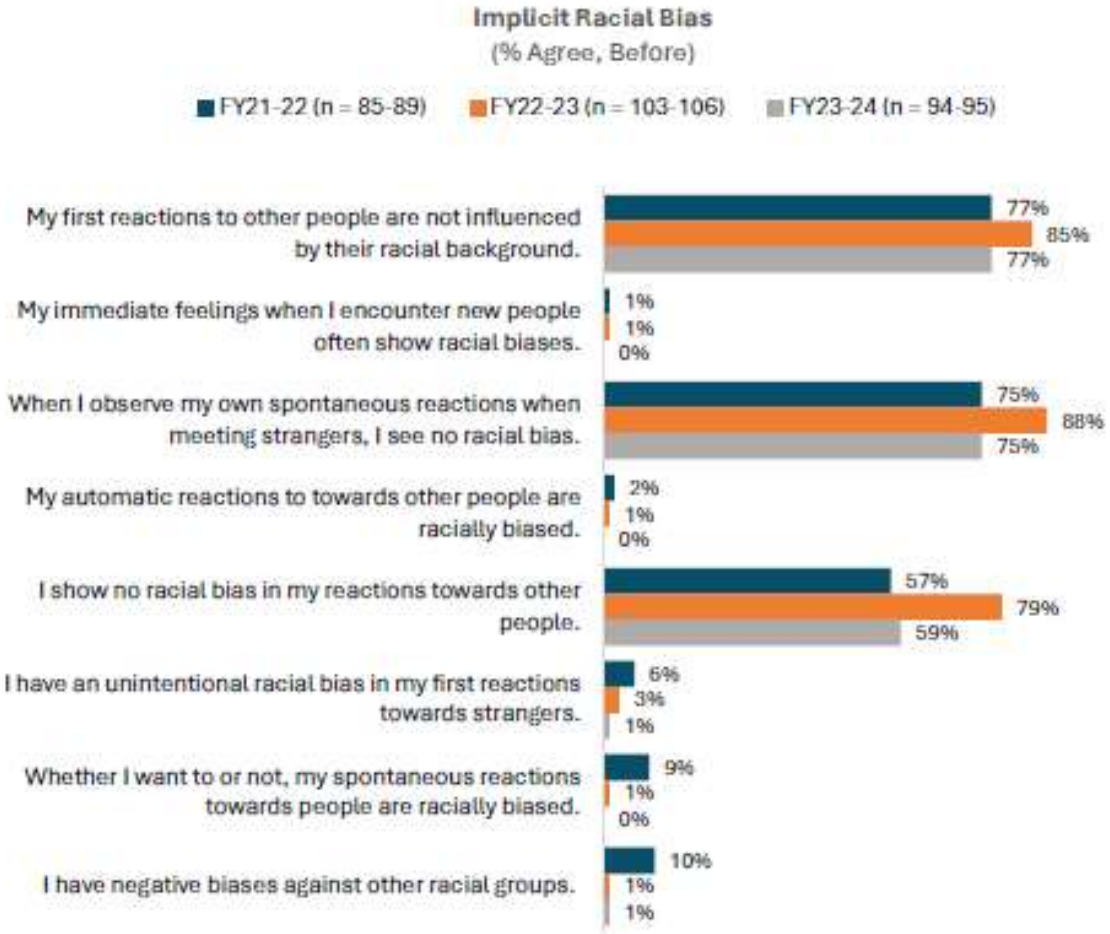
CRISIS INTERVENTION TEAM

Program Outcomes: Training Evaluation Survey



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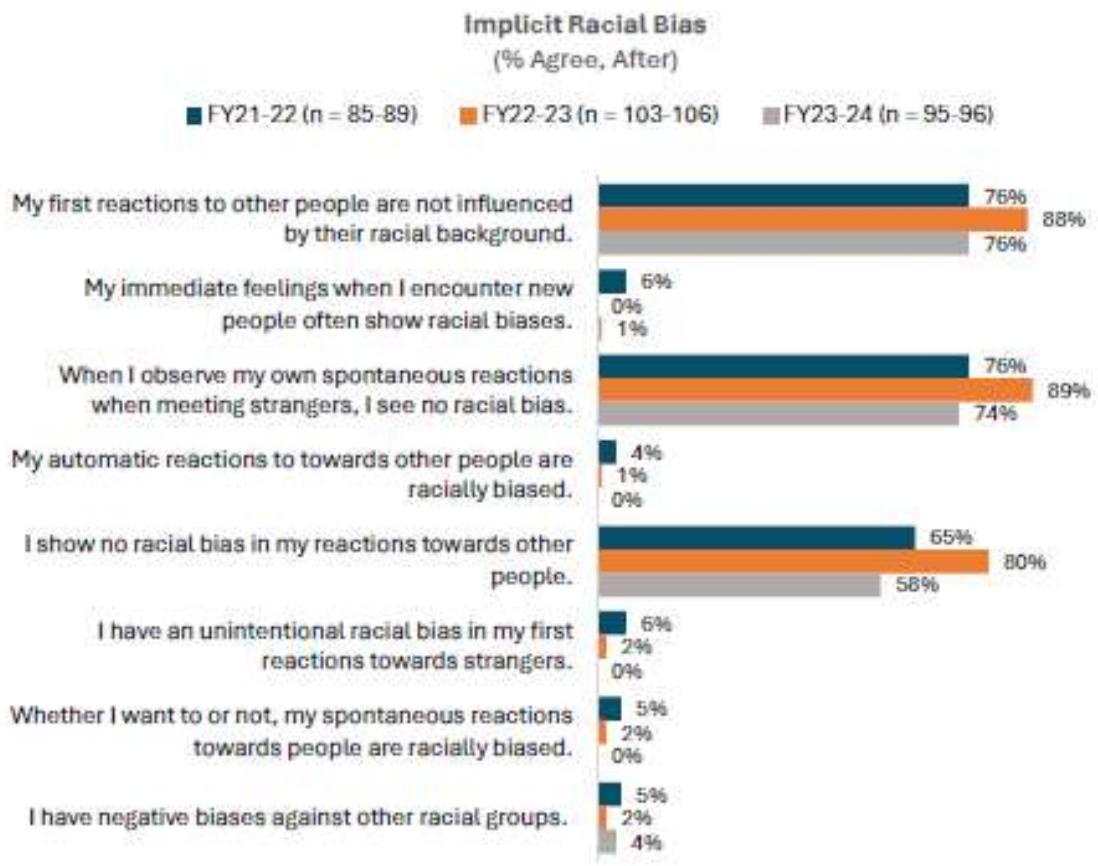
CRISIS INTERVENTION TEAM

Program Outcomes: Training Evaluation Survey



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CRISIS INTERVENTION TEAM

Program Outcomes: Follow-up Survey

Approximately 8 months after a CIT Academy training, trainees were asked to take a follow-up survey. The questions on this survey are intended to measure the outcome of the training, including how frequently trainees have implemented techniques learned from the training and their overall perceptions of the training. Results from this survey are presented below.

As a result of CIT training ...	FY21-22 (n = 67)	FY22-23 (n = 79-80)	FY23-24 (n = 50-52)
I am better able to recognize the signs and symptoms of a mental health disorder among individuals that I encounter in the community.	75%	90%	91%
I can effectively communicate with persons displaying signs of a mental health disorder.	75%	90%	88%
I am more comfortable interacting with persons displaying signs of a mental health disorder.	76%	90%	89%
I am better able to defuse aggression before it becomes violence.	67%	88%	88%
I feel more prepared to respond to an incident involving a person engaging in self-harming behavior or threatening suicide.	70%	89%	91%
I have more skills useful for managing any type of mental health crisis effectively.	73%	85%	91%

CIT training ...	FY21-22 (n = 67)	FY22-23 (n = 79-80)	FY23-24 (n = 52-53)
Increases law enforcement officer safety	66%	89%	93%
Increases the safety of those affected with mental health conditions.	76%	92%	91%
Better prepares law enforcement officers to handle crises involving individuals with a mental health disorder.	85%	91%	93%

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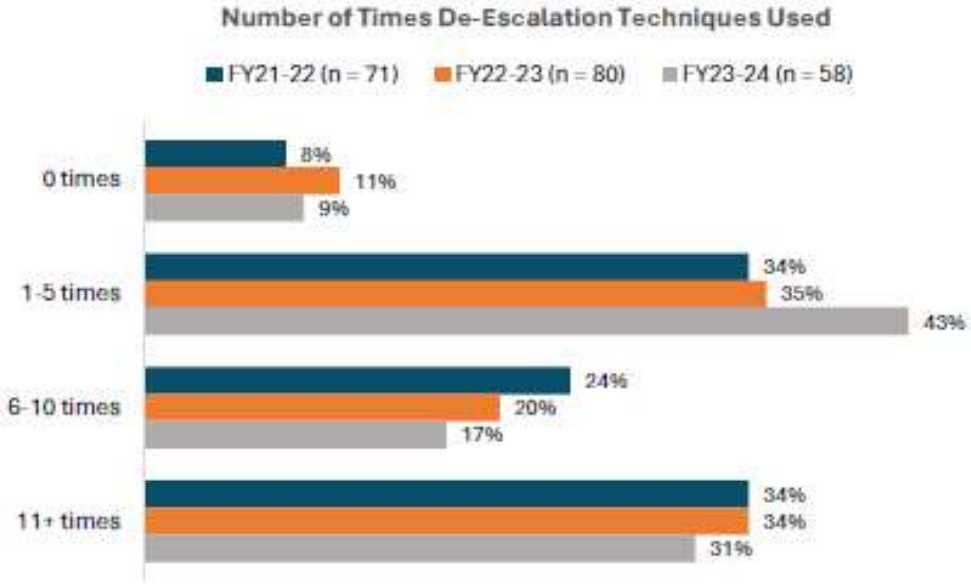
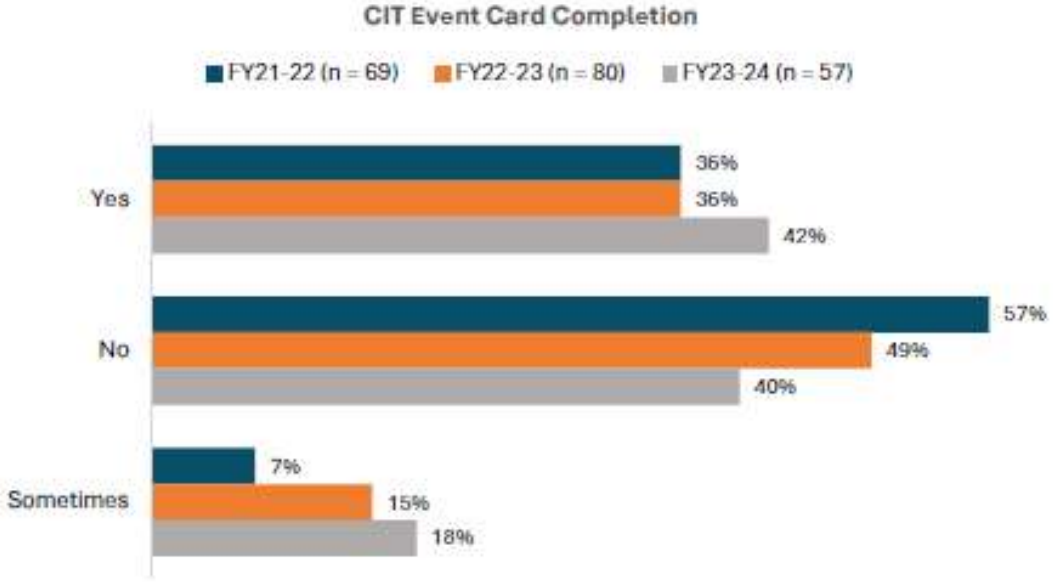
CRISIS INTERVENTION TEAM

Program Outcomes: Follow-up Survey





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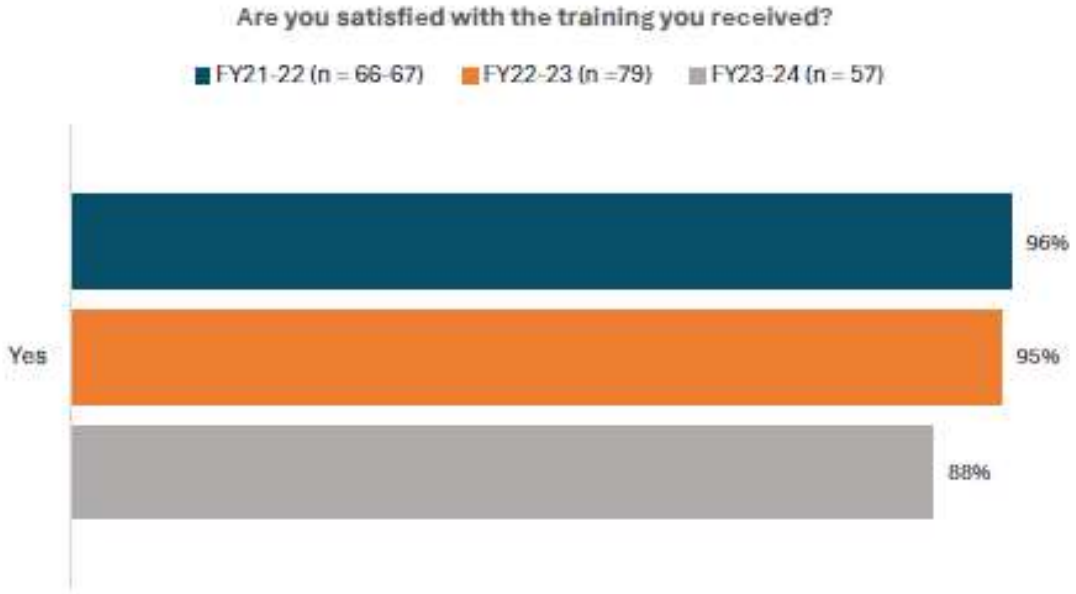
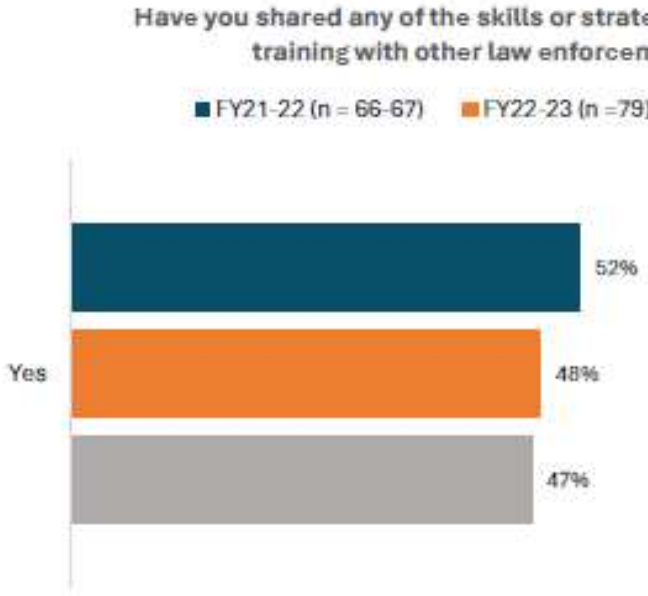
CRISIS INTERVENTION TEAM

Program Satisfaction

A series of questions evaluated CIT Academy trainees' satisfaction with their training. The responses to these satisfaction-related questions from the past three years are summarized below.





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CRISIS INTERVENTION TEAM

Program Satisfaction

CIT Academy trainees were asked 'How has the CIT training impacted how you do your job?". The chart below displays the top responses over the past three years and the number of participants who experienced this impact.

FY21-22 (n = 38)

How to communicate and interact with individuals in distress or with mental illness (15)

Have more patience and empathy (7)

Have a greater understanding of mental illness (6)

FY22-23 (n = 54)

How to communicate and interact with individuals in distress or with mental illness (15)

Have a greater understanding of mental illness (10)

FY23-24 (n = 88)

Tools/techniques for communicating and interacting with individuals in distress or with mental illness (40)

Greater understanding of mental illness/disability (23)

Increased knowledge of resources (23)

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CRISIS INTERVENTION TEAM

Program Feedback

Participants who completed CIT Academy training were asked to provide additional feedback through two open-ended response questions. Their comments were categorized by theme, with the most common responses highlighted. Given that the program has evolved over the past three years, and staff has actively addressed previous challenges, only feedback specific to the fiscal year 2023-2024 is included in the chart below.

What was most helpful about this program?	• The training provided participants with practical tools and resources, increased their awareness of mental health issues, and underscored the importance of empathy and thoughtful interactions in their roles.
What would make this program better?	• Some participants recommended less use of videos and PowerPoint presentations, suggesting more real-life examples and scenario-based training instead. They also proposed shortening the course and increasing involvement of speakers with personal experiences or mental health conditions.

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CRISIS INTERVENTION TEAM

Conclusion and Recommendations

The CIT program has demonstrated consistent effectiveness in training Ventura County first responders to handle mental health crises with empathy and skill. Throughout the three years, trainee feedback highlights strong gains in their ability to recognize and respond to signs of mental health conditions, defuse aggression, and improve communication with affected individuals. Increased comfort in handling mental health crises reflects the success of CIT's targeted, stigma-reduction curriculum. Additionally, follow-up survey data indicates that CIT training has positively impacted officer safety and the safety of individuals with mental health conditions, meeting core program objectives of de-escalation and pre-custody diversion.

Recommendations include expanding CIT training to more community partners and increasing opportunities for ongoing refresher courses. Trainees' feedback suggests a need for more frequent engagement with CIT principles, as this can reinforce learned skills and deepen confidence in managing diverse crisis scenarios. Furthermore, given the high percentage of trainees reporting comfort in using CIT techniques, the program may benefit from promoting peer-led skill-sharing sessions, where experienced trainees can share insights with newer participants, strengthening the overall knowledge base.

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DIVERSITY COLLECTIVE

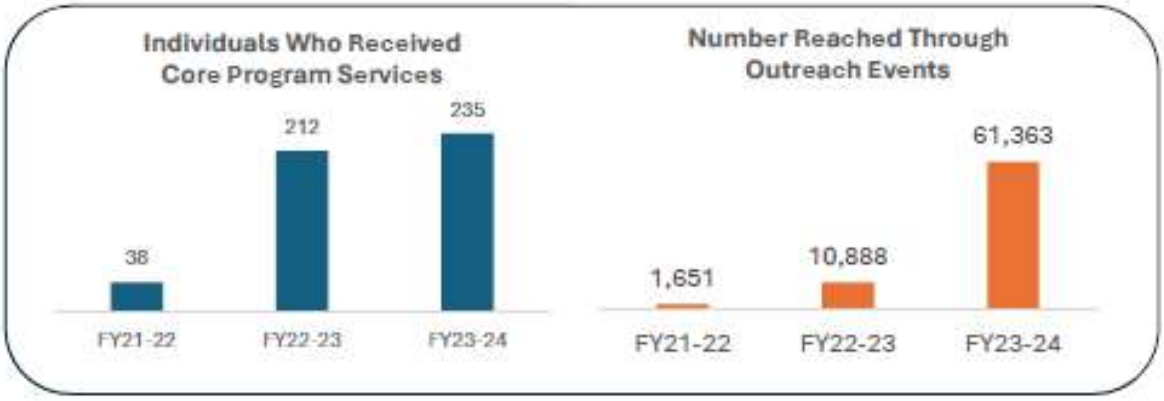
Diversity Collective is an affirming and welcoming space for LGBTQ+ youth ages 13 to 23 and their allies including peers, family, educators, and agency staff. Diversity Collective's trainings employ a variety of methods and activities to shift attitudes, enhance knowledge, and modify behaviors concerning the diagnosis of mental illness, living with mental health conditions, and seeking mental health services and then measure that impact through a validated instrument, the Mental Help Seeking Attitudes Scale (Hammer, Parent, & Spiker, 2018). The program's activities and events include interactive workshops that provide education on mental health issues specific to the LGBTQ+ community, peer support groups to share experiences and coping strategies, resilience and empowerment exercises tailored to address the unique challenges faced by LGBTQ+ individuals, and advocacy skills training to promote access to mental health services. Diversity Collection conducts P.R.I.D.E. (Parents & Professionals' Responsibility for Inclusion, Diversity, and Equity) trainings for Ventura County schools and community members.

Program Strategies

Improves timely access to services for underserved populations by providing social and emotional support and connections to mental health care to LGBTQ+ youth.

Implements non-stigmatizing and non-discriminatory practices by providing LGBTQ+ cultural competency trainings to potential responders and agency staff.

Program Highlights



VENTURA COUNTY BEHAVIORAL HEALTH
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DIVERSITY COLLECTIVE

Demographic Data

Diversity Collective collects unduplicated demographic data from the individuals it serves and trains. This section presents information from 483 individuals who completed a demographic form over the past three years.

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Race*	**n = 32**	**n = 212**	**n = 228**
American Indian/Alaska Native	3%	1%	1%
Asian	0%	5%	4%
Black/African American	0%	2%	2%
Hispanic/Latino	37%	48%	51%
Native Hawaiian, other Pacific Islander	0%	1%	0%
White	57%	33%	41%
More Than One Race	10%	8%	8%
Other	3%	1%	2%
Ethnicity*	**n = 31**	**n = 149**	**n = 154**
Hispanic/Latino			
Caribbean	0%	1%	0%
Central American	10%	5%	3%
Mexican/Mex.-Am./Chicano	48%	72%	65%
Puerto Rican	3%	0%	1%
South American	0%	2%	4%
Other Hispanic/Latino	6%	0%	0%
Non-Hispanic/Latino			
African	0%	1%	1%
Asian Indian/South Asian	0%	0%	1%
Cambodian	0%	0%	0%
Chinese	0%	1%	1%
Eastern European	6%	0%	5%
European	26%	5%	12%
Filipino	0%	2%	5%
Japanese	0%	1%	0%
Korean	0%	1%	0%
Middle Eastern	0%	0%	3%
Vietnamese	0%	1%	0%
More than one	6%	5%	0%
Other Non-Hispanic/Latino	0%	0%	2%

VENTURA COUNTY
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DIVERSITY COLLECTIVE

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Primary Language*	**n = 37**	**n = 212**	**n = 220**
English	86%	75%	89%
Spanish	14%	22%	30%
Indigenous (Mixteco or Other)	0%	0%	1%
Another Language	0%	0%	2%
Age Groups	**n = 36**	**n = 212**	**n = 234**
0-15 years	31%	38%	7%
16-25 years	58%	62%	32%
26-59 years	8%	0%	58%
60+ years	3%	0%	3%
Gender Identity*	**n = 30**	**n = 212**	**n = 222**
Male	50%	29%	18%
Female	40%	30%	65%
Transgender	30%	19%	11%
Genderqueer	0%	12%	6%
Questioning or Unsure	7%	4%	2%
Another Gender Identity	17%	4%	5%
Sex Assigned at Birth	**n = 24**	**n = 212**	**n = 221**
Male	25%	36%	18%
Female	75%	64%	81%
Sexual Orientation	**n = 34**	**n = 212**	**n = 210**
Heterosexual or Straight	18%	28%	62%
Gay or Lesbian	24%	17%	10%
Bisexual	24%	21%	11%
Queer	6%	15%	9%
Questioning or Unsure	6%	4%	6%
Another sexual orientation	26%	9%	2%
Disability	**n = 31**	**n = 212**	**n = 223**
Yes	48%	24%	17%
No	52%	76%	83%

VENTURA COUNTY
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DIVERSITY COLLECTIVE

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Disability Type*	**n = 15~**	**n = 51**	**n = 37**
Chronic Health Condition/Chronic pain	0%	0%	41%
Dementia	0%	0%	0%
Developmental disability	2%	10%	11%
Difficulty hearing or having speech understood	7%	3%	3%
Difficulty Seeing	27%	20%	8%
Another Communication Disability	7%	0%	0%
Learning Disability	73%	40%	35%
Mental Disability	3%	3%	0%
Physical/Mobility Disability	7%	5%	27%
Another Mental Disability	1%	0%	16%
Another Disability	7%	7%	0%
Veteran	**n = 29**	**n = 211**	**n = 222**
Yes	7%	0%	1%
No	93%	100%	99%

*Total may exceed 100% because participants could choose multiple response options.

~ Small sample sizes can make results less reliable and more affected by unusual values, so these findings should be viewed carefully

VENTURA COUNTY BEHAVIORAL HEALTH
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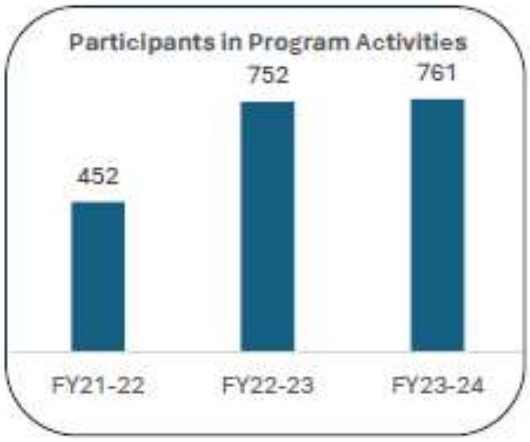
DIVERSITY COLLECTIVE

Program Activities & Outreach

Program activities include drop-in programs, trainings and workshops, meetings, and support groups facilitated by Diversity Collective program staff. Program participants and other community members may participate in these activities and events.

Activity Type	FY 21-22	FY 22-23	FY 23-24
Meeting	9	2	-
Training/Workshop	11	6	19
Mentor Meeting	9	-	-
Field Trip	1	-	-
Support Group	41	2	-
Drop-in Program	-	66	56
Class	-	-	2
Other	-	-	1
Total Activities	71	76	78

Program Outreach Type	FY 21-22	FY 22-23	FY 23-24
Community Fair or Event	3	52	35
Presentation	1	1	2
Outreach/Outreach Misc.	6	1	28
Meeting or Interagency Meeting	1	2	13
Education	1	2	1
Faith Based	-	-	1
Workshop	-	-	6
Education	-	-	1
Other	1	-	1
Total Outreach Activities	13	58	88



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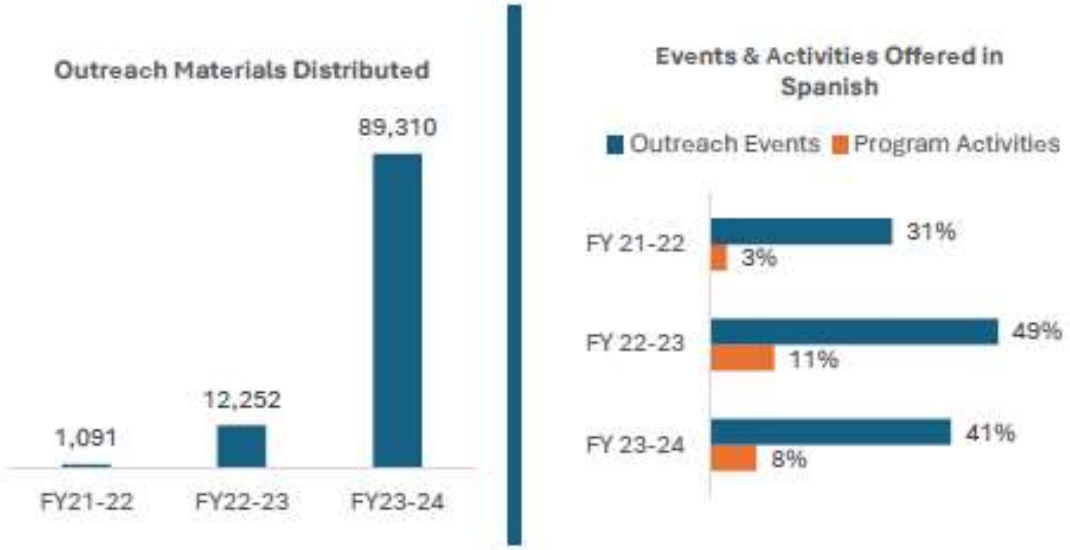
DIVERSITY COLLECTIVE

Program Activities & Outreach (continued)



From FY21-22 to FY23-24:

The number of participants in program activities increased by 35%

The number of outreach materials distributed increased by 629%

VENTURA COUNTY
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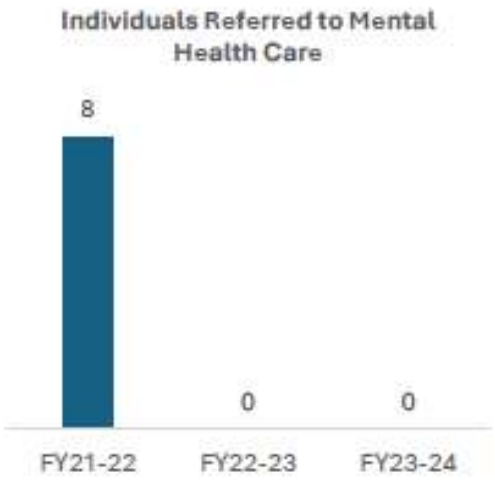
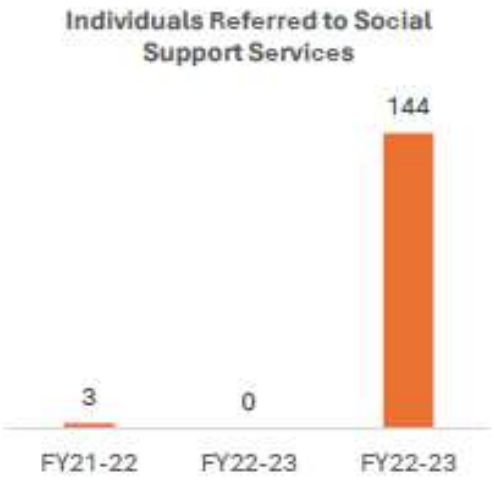
DIVERSITY COLLECTIVE

Program Referrals

Program referrals include mental health care referrals to VCBH or other MHSA PEI or treatment programs. Diversity Collective also provides referrals to social support such as food, housing, health insurance, and other support services. The highlighted referral data represents unduplicated individuals who could be referred to multiple services.





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DIVERSITY COLLECTIVE

Program Outcomes

Diversity Collective tracks outcomes by surveying participants who receive services offered by the organization. Participant outcomes are assessed at two time points (intake and exit) using the Schwartz Outcome Scale (SOS-10), a 10-item measure of psychological health. Higher scores on this measure indicate greater psychological well-being/lower levels of distress. Comparisons of intake and exit scores for the past three years are presented in the chart below. SOS-10 exit data were not available for FY23-24.

Schwartz Outcome Scale (SOS-10)		FY 21-22 Intake = 7, Exit =5	FY 22-23 Intake = 80, Exit =66	FY 23-24 Intake = 8, Exit = N/A
Minimal	Intake	43%	60%	13%
	Exit	40%	91%	-
Mild	Intake	14%	15%	13%
	Exit	20%	9%	-
Moderate	Intake	43%	16%	25%
	Exit	20%	0%	-
Severe	Intake	0%	0%	49%
	Exit	20%	9%	-

Each year:

Each year, participants reported minimal levels of distress, on average:
39% at Intake
66% at Exit

VENTURA COUNTY BEHAVIORAL HEALTH
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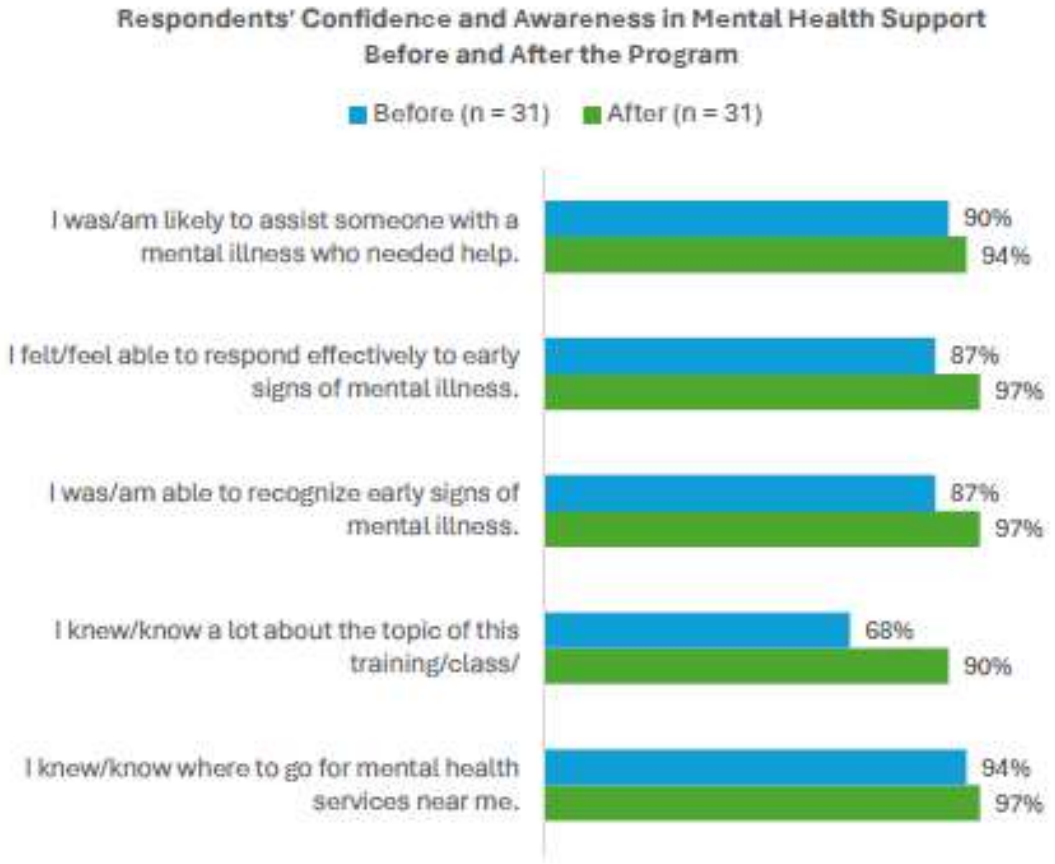
DIVERSITY COLLECTIVE

Program Outcomes

Diversity Collective also surveyed participants on their knowledge before and after participating in the program during FY23-24. The results for those who agreed or strongly agreed are shown below.



VENTURA COUNTY BEHAVIORAL HEALTH
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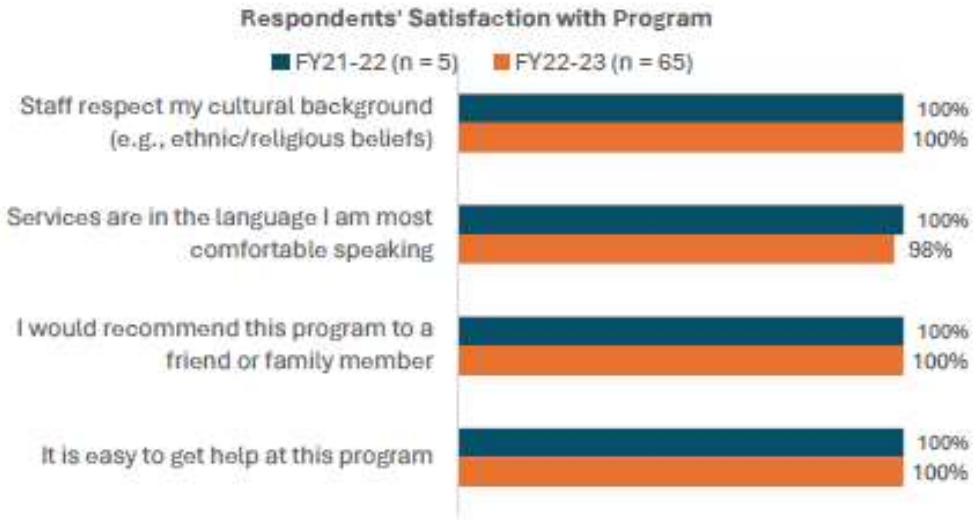
DIVERSITY COLLECTIVE

Program Satisfaction

Participants were asked to indicate the extent to which they disagreed or agreed with several statements about the program as a measure of their satisfaction with the Diversity Collective program and services. The number of participants who agreed or strongly agreed with each statement is shown in the chart below. Data from FY-23-24 are presented separately as different items were used to measure program satisfaction.



Virtually all participants were *completely satisfied* with Diversity Collective's program and staff.

VENTURA COUNTY
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DIVERSITY COLLECTIVE

Areas of Support

Participants were asked to select areas in which they needed additional support from a list of nine options. The chart below displays top Areas of Need* and the number of participants who indicated they needed help in each area.

FY21-22 (n = 5)
- Mental health: **80%**
- Relationships with friends and family: **40%**

FY22-23 (n = 66)
- Mental health: **88%**
- Relationships with friends and family: **29%**
- Grades in school: **18%**

FY23-24 (n = 13)
- Relationships with friends and family: **54%**
- Mental health: **46%**
- Job Situation: **23%**

*Total percentage may exceed the number of participants because they could choose more than one response option.

VENTURA COUNTY
BEHAVIORAL HEALTH
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DIVERSITY COLLECTIVE

Program Feedback

Participants who received program services from Diversity Collective were asked to provide additional feedback through two open-ended response questions. Their comments were categorized by theme, with the most common responses highlighted. Given that the program has evolved over the past three years, and staff has actively addressed previous challenges, only feedback specific to the fiscal year 2023-2024 is included in the chart below.

What was most helpful about this program?	•Participants found the educational content on LGBTQ+ identities and mental health risks very helpful. They valued the practical resources provided, the interactive elements of the training, and the opportunity to challenge their biases, broaden their perspectives, and foster empathy and allyship.
What would make this program better?	•Participants desired longer sessions to cover topics more thoroughly and enhance interaction. They requested specific (e.g., mental health of LGBTQ+ older adults, the importance of pronouns), and suggested improving content accessibility to ensure the program reaches a braoder audience.

VENTURA COUNTY
BEHAVIORAL HEALTH
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DIVERSITY COLLECTIVE

Conclusions and Recommendations

Diversity Collective has created a meaningful and supportive environment for LGBTQ+ youth and their allies, making substantial progress in raising awareness, fostering knowledge, and building empathy among participants. With a diverse array of activities, including P.R.I.D.E. trainings, interactive workshops, peer support groups, and advocacy skills sessions, the program offers holistic support tailored to the unique needs of the LGBTQ+ community. Substantial growth in outreach, demonstrated by increased participation and distribution of materials, reflects the program's expanding influence within Ventura County.

Participant feedback has highlighted the training content's relevance, particularly regarding LGBTQ+ identities and mental health risks, as well as the program's ability to broaden perspectives and foster allyship. To further enhance impact, participants have suggested extending sessions to cover specific topics in greater depth, such as mental health in older LGBTQ+ adults and the importance of pronouns and making materials more accessible to reach a broader audience. Offering content in various languages and formats could also help engage more diverse groups. Expanding outreach to traditionally underserved populations may further amplify the program's positive impact. Diversity Collective's dedication to fostering an affirming and welcoming space is clearly resonating, with opportunities to deepen its reach and effectiveness.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

LA CLAVE EDUCATION AND TRAINING
VENTURA COUNTY BEHAVORIAL HEALTH AND USC

Ventura County Behavioral Health partnered with USC to provide a new outreach addition to help recognize early signs of mental illness, especially for those with psychosis. The goal of the La CLAve Education and Training program was to train potential Ventura County Behavioral Health (VCBH) staff and community collaborators to deliver an evidence-based workshop that targets the Latino community in Ventura County to identify the symptoms of serious mental health illness and assist them in seeking services for early treatment. This training was conducted in three phases: (1) train 32-40 facilitators, (2) select 3-4 of the best facilitators to become trainers of future facilitators, and (3) evaluate the training. Results from this partnership are written up separately in this report's appendix. Upon the conclusion of phase three, providers continue to host trainings across the county, and those data are displayed below.

Program Strategies

Increases recognition of early signs of psychosis through outreach and trainings to Latino community members. Improves timely access to services for underserved populations (Latino community) who might not get help otherwise.

Implements non-stigmatizing and non-discriminatory practices by providing culturally competent trainings to trained facilitators.

Program Highlights

33 Individuals received La CLAve Training

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

LA CLAVE EDUCATION AND TRAINING

Demographic Data

La CLAve collects unduplicated demographic data from individuals who received training. Demographic data from 33 individuals who completed outcome surveys are presented below.

Demographic Category	FY 21-22
Race*	**n = 31**
American Indian/Alaska Native	3%
Asian	0%
Black/African American	3%
Hispanic/Latino	59%
Native Hawaiian, other Pacific Islander	0%
White	35%
More Than One Race	0%
Other	0%
Ethnicity*	**n = 27**
Hispanic/Latino	
Caribbean	0%
Central American	0%
Mexican/Mex.-Am./Chicano	67%
Puerto Rican	0%
South American	0%
Other Hispanic/Latino	0%
Non-Hispanic/Latino	
African	0%
Asian Indian/South Asian	0%
Cambodian	0%
Chinese	0%
Eastern European	7%
European	10%
Filipino	0%
Japanese	0%
Korean	0%
Middle Eastern	3%
Vietnamese	0%
More than one	0%
Other Non-Hispanic/Latino	20%

VENTURA COUNTY
BEHAVIORAL HEALTH
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LA CLAVE EDUCATION AND TRAINING

Demographic Category	FY 21-22
Primary Language*	**n = 31**
English	45%
Spanish	39%
Indigenous	-
English and Spanish	16%
Age Groups	**n = 31**
0-15 years	6%
16-25 years	53%
26-59 years	22%
60+ years	19%
Gender Identity	**n = 30**
Male	13%
Female	87%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%
Sex Assigned at Birth	**n = 31**
Male	13%
Female	87%
Sex Sexual Orientation	**n = 27**
Heterosexual or Straight	92%
Gay/Lesbian	0%
Bisexual	4%
Queer	4%
Questioning/Unsure	0%
Another sexual orientation	0%
Disability Status	**n = 30**
Yes	30%
No	70%

VENTURA COUNTY BEHAVIORAL HEALTH
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LA CLAVE EDUCATION AND TRAINING

Demographic Category	FY 21-22
Disability Type†	**n = 9^**
Chronic Health Condition/Chronic Pain	11%
Dementia	0%
Developmental disability	0%
Difficulty Hearing, or having speech understood	0%
Difficulty Seeing	44%
Learning Disability	0%
Physical/Mobility Disability	11%
Another Disability	33%
Veteran	**n = 32**
Yes	3%
No	97%

*Total may exceed 100% because participants could choose multiple response options.

†Total is less than 100% due to rounding.

^ Small sample sizes can make results less reliable and more affected by unusual values, so these findings should be interpreted cautiously.

VENTURA COUNTY
BEHAVIORAL HEALTH
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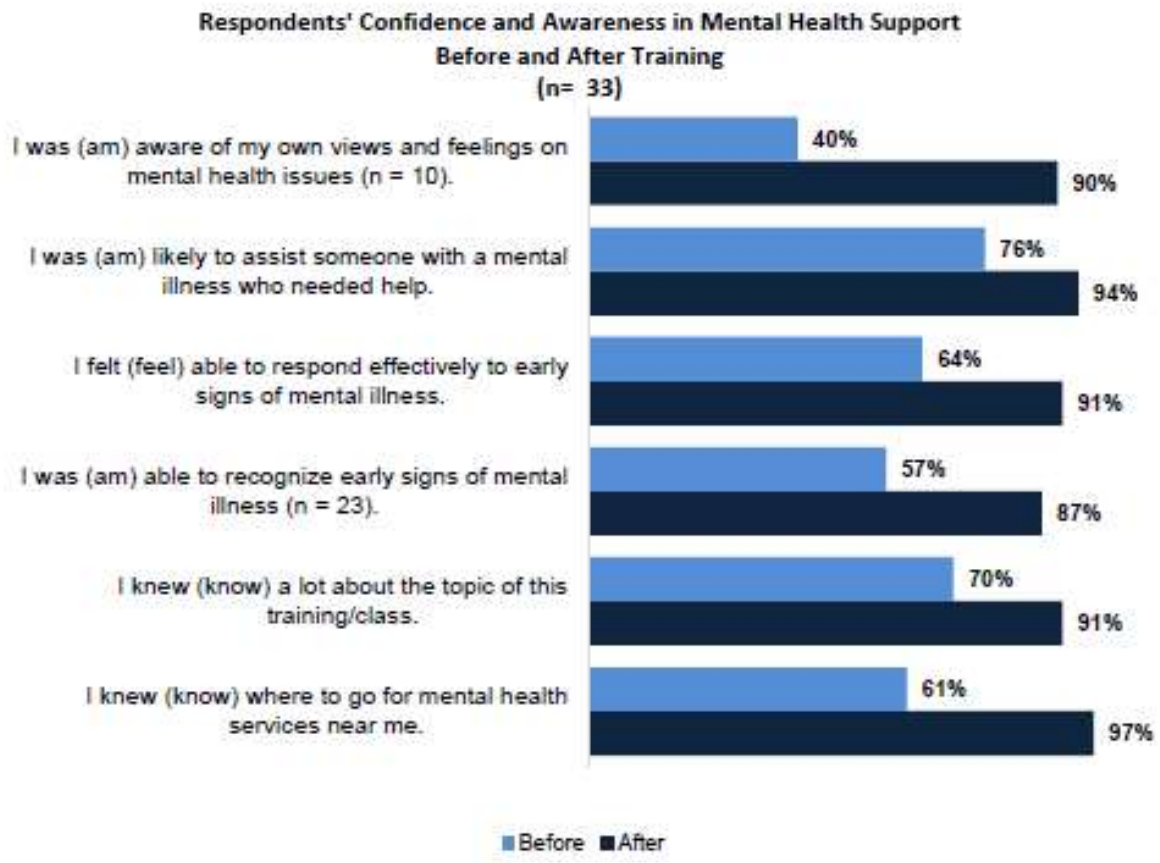
LA CLAVE EDUCATION AND TRAINING

Program Outcomes

La CLAve tracks outcomes for individuals who attended presentations by asking participants to self-assess their knowledge from two perspectives (retrospective pre/post): Before and after the training. Survey results are presented in the table below.



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BEHAVIORAL HEALTH
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LA CLAVE EDUCATION AND TRAINING

Program Satisfaction

To measure their satisfaction with LA CLAve training, participants were asked to indicate the extent to which they disagreed or agreed with several statements. The percentage of participants who agreed or strongly agreed with each statement is shown in the chart below.

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BEHAVIORAL HEALTH
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LA CLAVE EDUCATION AND TRAINING

Areas of Support

Participants were asked to select areas where they needed additional support from a provided list of options. The list below highlights the top support areas identified.

FY21-22 (n = 33)

- Mental health: **45%**
- Relationships with family and friends: **30%**
- Parenting: **21%**

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LA CLAVE EDUCATION AND TRAINING

Program Feedback

Participants who received training from La CLAve were asked to provide additional feedback through two open-ended response questions. Their comments were categorized by theme, with the most common responses highlighted.

What was most helpful about this program?

- How to identify and understand mental illness
- Training materials (e.g., brochure, visual aids)
- Information and resources

What would make this program better?

- Greater variety (e.g., mental illness in teens, school workshops) and frequency of training
- Additional resources and services that can be provided to others

VENTURA COUNTY
BEHAVIORAL HEALTH
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LA CLAVE EDUCATION AND TRAINING

Conclusions and Recommendations

La CLAve effectively addresses the needs of its target community in Ventura County, primarily serving the Hispanic/Latino population. Program data indicate that participants gained a better understanding of their own views and feelings about mental health issues after the training and became more likely to assist someone experiencing a mental illness. La CLAve successfully met participants' expectations with most (82%) expressing high satisfaction with the training. While half of the participants indicated that no improvements were needed, one potential area for enhancement could be offering a greater variety of training topics.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

LOGRANDO BIENESTAR

The Logrando Bienestar program is designed to help the Latino community understand the importance of mental and emotional health, with the goal of helping individuals access services for productive and healthy lifestyles. Logrando Bienestar walks participants through the process of getting well. The program serves youth and adults countywide.

Program Strategies

Increases recognition of early signs of mental illness by providing trainings to educators and other potential responders.

Implements non-stigmatizing and non-discriminatory practices by dispelling myths and sharing information in English and Spanish.

Program Highlights

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

LOGRANDO BIENESTAR

Demographic Data

Logrando Bienestar collects unduplicated demographic data from the individuals they serve. This section presents information from 5,030 individuals whose information was entered into VCBH's Electronic Health System (EHR) over the past three years. The EHR system changed in FY23-24 and collected some information differently than in prior years.

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Race*	**n = 1,649**	**n = 1,274**	**n = 915**
American Indian/Alaska Native	1%	<1%	1%
Asian	1%	1%	1%
Black/African American	1%	1%	2%
Hispanic/Latino†	73%	-	-
Native Hawaiian, Other Pacific Islander	0%	0%	1%
White	25%	30%	42%
More Than One Race	0%	0%	-
Other	0%	68%	53%
Ethnicity*	**n = 1,230**	**n = 992**	**n = 985**
Hispanic/Latino	97%	76%	92%
Mexican/Mex.-Am./Chicano	70%	76%	-
Puerto Rican	0%	<1%	-
Other Hispanic/Latino	27%	0%	-
Non-Hispanic/Latino	10%	19%	7%
African	0%	0%	-
Asian Indian/South Asian	0%	0%	-
Cambodian	0%	0%	-
Chinese	0%	0%	-
Eastern European	0%	0%	-
European	0%	0%	-
Filipino	0%	0%	-
Japanese	0%	0%	-
Korean	0%	0%	-
Middle Eastern	0%	0%	-
Vietnamese	0%	0%	-
More than one	0%	0%	<1%
Other Non-Hispanic/Latino	10%	19%	-

VENTURA COUNTY BEHAVIORAL HEALTH
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LOGRANDO BIENESTAR

Demographic Category	FY 21-22	FY 22-23	FY 23-24
Disability Type*	**n = 42**	**n = 21**	**n/a**
Seeing	57%	5%	-
Hearing	2%	19%	-
Another Communication Disability	0%	5%	-
Learning	7%	14%	-
Developmental	2%	19%	-
Mental	0%	5%	-
Physical/Mobility	0%	14%	-
Chronic Health Condition	5%	5%	-
Other	26%	14%	-
Veteran Status	**n = 77**	**n = 1,278**	**n/a**
Yes	0%	0%	-
No	100%	100%	-

*Total may exceed 100% because participants could choose multiple response options.
†Hispanic/Latino was not a race option in FYs 22-23 and 23-24 per State regulations.
ˇEthnicity subgroups and Disability were not collected in FY 23-24
ˆ Gender Identity was not collected in FY 22-23

VENTURA COUNTY BEHAVIORAL HEALTH
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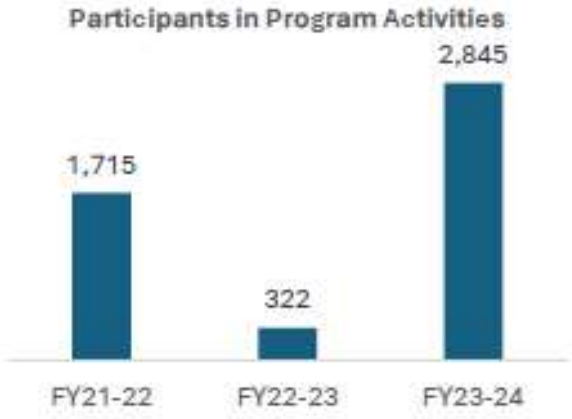
LOGRANDO BIENESTAR

Program Activities & Outreach

Program activities include workshops facilitated by program staff. Over the last three years, Logrando Bienestar has provided 2,179 program activities and outreach.

Activity Type	FY 21-22	FY 22-23	FY 23-24
Drop-in Program	33	-	-
Individual Activity	115	-	-
Meeting	14	-	-
Training/Workshop	61	21	384
Support Group	1	-	-
Other	3	-	-
Total Activities	**227**	**21**	**384**

Program Outreach Type	FY 21-22	FY 22-23	FY 23-24
Community Fair/Event	-	-	6
Informational Session	1	-	
Personal/Individual	1	-	-
Presentation	4	-	-
Meeting	10	-	-
Promotion	41	-	-
Outreach	310	608	551
Total Outreach Activities	**367**	**608**	**557**



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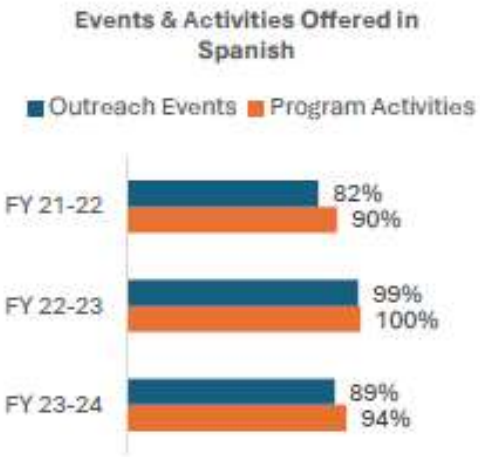
LOGRANDO BIENESTAR

Program Activities & Outreach (continued)



From FY21-22 to FY23-24:

The number of participants in program activities increased by 784% in the past fiscal year[†]

[†]Number of people reached may be duplicated because individuals could attend multiple activities.

VENTURA COUNTY
BEHAVIORAL HEALTH
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LOGRANDO BIENESTAR

Program Outcomes

Logrando Bienestar tracks outcomes for program participants (i.e., those who receive services) by asking participants to self-assess their knowledge from two perspectives (retrospective pre/post): before and after they received services. In FY 21-22, participants reported an average difference of 27% in knowledge after receiving services. Revisions to the data tool were made after FY21-22, and results for FYs 22-23 and 23-24 are presented in the charts below.

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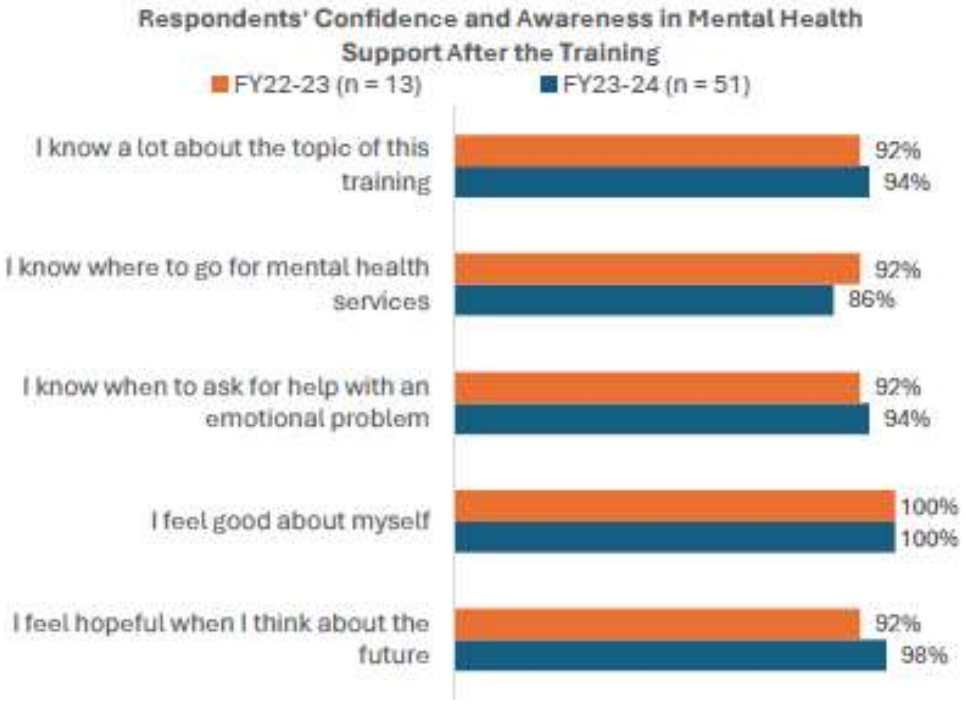
LOGRANDO BIENESTAR



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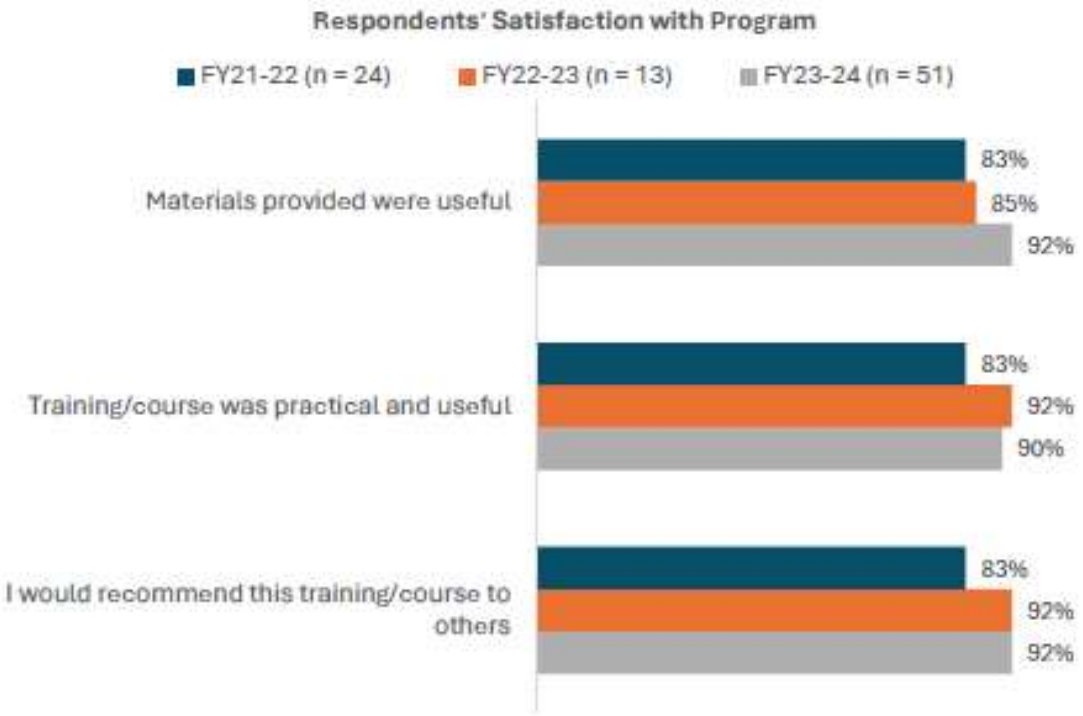
LOGRANDO BIENESTAR

Program Satisfaction

Participants were asked to indicate the extent to which they disagreed or agreed with several statements about the program as a measure of their satisfaction with the Logrando Bienestar program and services. The chart below shows the percentage of participants who strongly agreed or agreed with each statement over the past three years.



Most participants were *completely satisfied* with Logrando Bienestar's trainings/courses.

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LOGRANDO BIENESTAR

Areas of Support

Participants were asked to select areas where they needed additional support from a provided list of options. The list below highlights the top support areas identified over the past three years. These insights can guide providers in enhancing services for the upcoming fiscal year.

FY21-22 (n = 21)

- Parenting: **76%**
- Mental health: **57%**
- Relationships with family and friends: **43%**

FY22-23 (n = 10)

- Relationships with friends and family: **40%**
- Mental health: **30%**
- Parenting: **20%**

FY23-24 (n = 36)

- Mental health: **61%**
- Parenting: **56%**
- Relationships with friends and family: **31%**

*Total percentage may exceed number of participants because they could choose more than one response option.

VENTURA COUNTY
BEHAVIORAL HEALTH
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LOGRANDO BIENESTAR

Program Feedback

Participants who received program services from Logrando Bienestar were asked to provide additional feedback through two open-ended response questions. Given that the program has evolved over the past three years, and staff has actively addressed previous challenges, only feedback specific to the fiscal year 2023-2024 is included in the chart below.

What was most helpful about this program?	•Participants valued information the program provided on mental health warning signs, community resources, and effective family communication. The program has practical applications that helped participants improve their communication, be more engaged with their children, and prevent bullying.
What would make this program better?	•Participants recommended making the program more accessible to a wider audience by providing information in Spanish, using translators for Indigenous languages, and offering more classes. They also suggested reducing response times, wait times, more therapists, and fewer changes in assigned therapists.

VENTURA COUNTY
BEHAVIORAL HEALTH
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LOGRANDO BIENESTAR

Conclusions and Recommendations

Over the past three years, Logrando Bienestar has reached a substantial number of participants through various program activities and outreach efforts, engaging a wide demographic, with a majority of Hispanic/Latino participants. The program's activities have evolved, with a notable increase in workshops and trainings, reflecting a shift towards structured, informative sessions. This evolution suggests that the program has successfully adapted to meet community needs by emphasizing knowledge-building activities, which aligns with its goal of empowering individuals to lead productive and healthy lives.

Finally, program data reveal a consistently high satisfaction rate among participants, indicating the program's success in meeting participant expectations. To build on this success, it is recommended to expand accessibility by providing information in Spanish, incorporating translators for Indigenous languages, and offering more classes. Additionally, reducing response and wait times, ensuring a stable assignment of therapists, and increasing the number of available therapists will enhance service delivery.

VENTURA COUNTY
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NETWORK EXPANSION GRANTS PROGRAM
OTHER PEI PROGRAMS

The Network Expansion Grants Program (NEGP) are time-limited, community-based projects or programs promoting wellness among Ventura County residents. NEGP activities were held between May 2023 and June 2024. NEGPs provided services to un- and underrepresented populations to reduce stigma and discrimination related to mental illness and seeking mental health support. These programs also sought to connect individuals experiencing mental illness to care and treatment.

Program Criteria

New projects/programs supporting un- and underserved populations or regions with prevalent health disparities

Application of new, peer-based approaches to community wellness including:

1) meaningful input from community members in project/program development
2) promotion of individual empowerment, resiliency, and self-determination for participants

Program Highlights

2 grants awarded (and 2 incomplete)

215 individuals engaged in program activities

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

NETWORK EXPANSION GRANTS PROGRAM
OTHER PEI PROGRAMS

Overview of NEGP Grantees

Two NEGPs provided services to increase inclusion, equity, and care for individuals experiencing mental illness; two were not completed. Below is a summary of each NEGP grantee.

Oxnard Performing Arts Center Corporation (OPAC) presented the Art is Wellness Summer Club program consisting of wellness-related in-person and online activities aimed toward low-income, underserved Latino youth and families from Oxnard seeking mental wellness information and arts activities. The program included family-oriented sensorial experiences such as drum circles, dancing, and gardening, coupled with resource tables and displays containing mental health information and resources representing underserved populations. There was also a button-making station with mental health-related statements. For those unable to attend, OPAC dedicated a section of its website to mental health and created a series of easy-to-follow videos and art therapy-related activities.

Women of Substance, Men of Honor (WOSMOH) targeted current and former foster youth, juvenile justice-involved youth, and formerly incarcerated youths ages 18-28, including Latino, BIPOC, and other marginalized populations in the TAY HOPE (Transitional Age Youth Helping Our Population Excel) Wellness Events. The program included focus groups, resource fairs, and workshops to develop and distribute learning tools to build and manage the impact of surviving systems of oppression.

LUCHA (Fiscal Agent for Poder Popular) (grant incomplete) would have targeted residents of Santa Paula, CA, who were farmworkers, seniors, LGBTQ+ individuals, youth, immigrants, low-income, unhoused, and members of other marginalized groups for the Adelante project. The project consisted of providing monthly Community Engagement Events to promote mental health wellness through cultural enrichment activities to local marginalized populations within a social safety net support system that helped stabilize and motivate residents to advocate for themselves, their families, and their neighborhoods.

Open Door Studio (grant incomplete) would have produced a one-month interactive and immersive exhibit, All the Feels Sensory Museum. They would have partnered with other organizations focused on mental health and wellness to serve underserved artists with autism and other neurodivergent disabilities in collaboration, design, and creation of the exhibit. It would have also served the entire community, as they could learn more about art, local mental health resources, inclusion, and living with a disability.

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NETWORK EXPANSION GRANTS PROGRAM
OTHER PEI PROGRAMS

Demographic Data

Below is demographic information for individuals who received services related to mental health care coordination or reducing mental health stigma and discrimination. All programs were conducted in FY 23-24.

Demographic Category	FY 23-24†
Race*	**n = 207**
American Indian/Alaska Native	2%
Asian	0%
Black/African American	5%
Hispanic/Latino	85%
Native Hawaiian, other Pacific Islander	0%
White	8%
More Than One Race	<1%
Another Race	2%
Hispanic/Latino Ethnicity	**n = 123**
Mexican/Mexican American/Chicano	93%
Central American	4%
Puerto Rican	1%
South American	0%
Another Hispanic/Latino ethnicity	2%
Another Hispanic/Latino Ethnicity	**n = 1**
Non-Hispanic/Latino Ethnicity	0%
Asian Indian/South Asian	0%
European	0%
Eastern European	0%
African	100%
Filipino	0%
Middle Eastern	0%
Another non-Hispanic/Latino ethnicity	0%
Primary Language*	**n = 214**
English	68%
Spanish	40%
Indigenous	1%
Both English & Spanish	12%
Another Language	<1%

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NETWORK EXPANSION GRANTS PROGRAM
OTHER PEI PROGRAMS

Demographic Category	FY 23-24†
Age Groups	**n = 210**
0-15 years	14%
16-25 years	29%
26-45 years	16%
46-59 years	21%
60+ years	20%
Gender Identity	**n = 131**
Female	84%
Male	16%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%
Sexual Orientation	**n = 100**
Heterosexual or Straight	94%
Bisexual	2%
Gay or Lesbian	2%
Queer	0%
Questioning or unsure	2%
Another sexual orientation	-
Disability	**n = 122**
Yes	16%
No	84%
Disability Status	**n = 19**
Difficulty seeing	37%
Difficulty hearing, or having speech understood	11%
Another communication disability	0%
Learning disability	16%
Developmental disability	5%
Dementia	5%
Another mental disability, not related to mental illness	5%
Physical/mobility disability	42%
Chronic health condition/chronic pain	0%
Another disability	0%
Veteran	**n = 131**
Yes	1%
No	99%

*Total may exceed 100% because participants could choose multiple response options.

† WOSMOH only reported race, primary language, and age.

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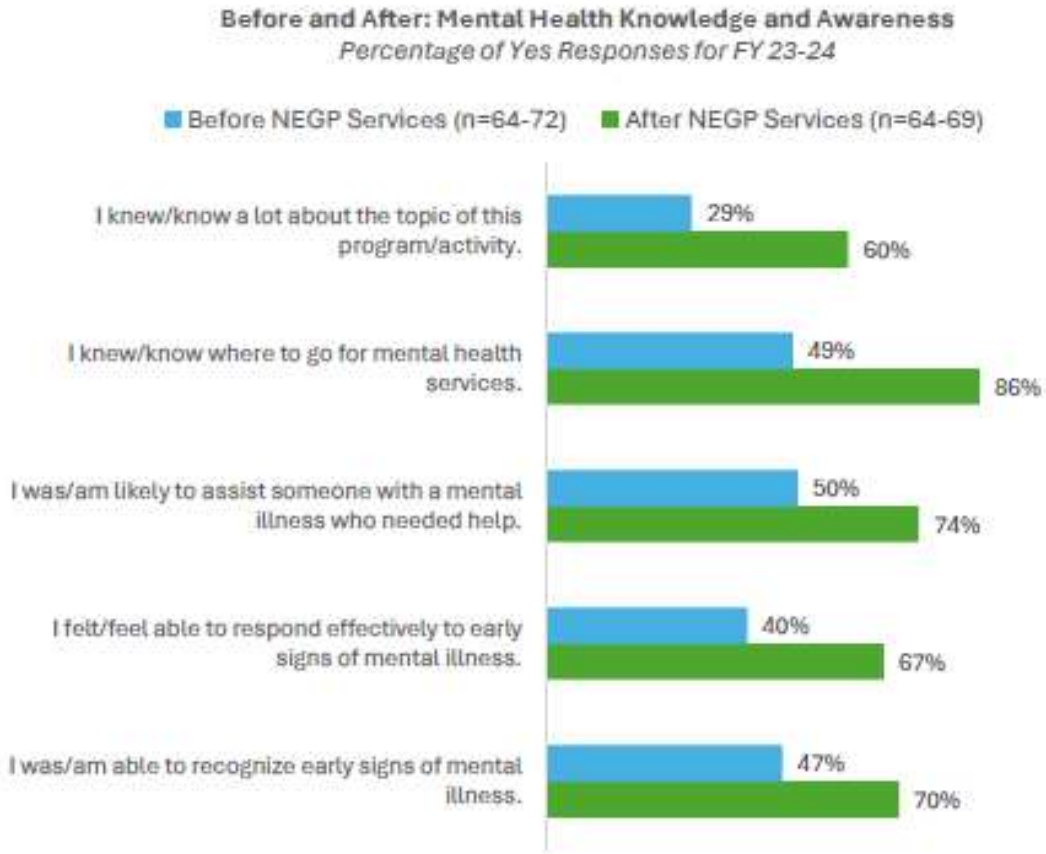
NETWORK EXPANSION GRANTS PROGRAM
OTHER PEI PROGRAMS

Program Outcomes

NEGP grantee OPAC tracked program outcomes by asking respondents to self-assess their mental knowledge and awareness from two perspectives (retrospective pre/post): before and after services. Survey results were only collected in FY 2023-2024 and are presented in the chart below.



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NETWORK EXPANSION GRANTS PROGRAM OTHER PEI PROGRAMS

Program Activities

NEGP grantee WOSMOH's activities included gathering information about community needs, hosting resource fairs, and distributing valuable resources to formerly incarcerated individuals and/or those involved with the foster care system (see below).

Activity Type	FY 23-24
Resource Fairs	2
Engagement Events	5
Connection Events with Local Organizations	3
Total Activities	10

Key Findings from **HOPE Healing Circles in Residential Treatment Programs:**

- **Locations:** Thousand Oaks, Ventura, and Oxnard
- **Participant Ages:** Primarily 14-21, with a few participants over 21
- **Program Focus:** Emphasis on mutual support and personal growth through HOPE healing circles

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NETWORK EXPANSION GRANTS PROGRAM
OTHER PEI PROGRAMS

Program Satisfaction

OPAC respondents were asked to indicate the extent to which they disagreed or agreed with several statements about the program/activity as a measure of their satisfaction with the NEGP services. The number of respondents who agreed or strongly agreed with each statement is shown in the chart below. Data was only collected in FY 2023-2024.

Respondents Feedback on Program Effectiveness
Percentage of Agree/Strongly Agree Responses for Key Statements
(n=71-73)

Most respondents expressed complete satisfaction with NEGP program activities.

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NETWORK EXPANSION GRANTS PROGRAM
OTHER PEI PROGRAMS

Areas of Support

OPAC respondents were asked to select areas where they needed additional support from a list of nine options. The figure below displays the top Areas of Need and the percentage of respondents who indicated they needed help in each area. These insights can guide providers in enhancing services for the upcoming fiscal year.

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NETWORK EXPANSION GRANTS PROGRAM OTHER PEI PROGRAMS

Feedback

Respondents who received program services from OPAC provided additional feedback through two open-ended response questions. Their comments were categorized by theme and descriptions are presented in the table below.

NEGP Grantee	Most Helpful About Program	Program Improvements
Oxnard Performing Arts Center	• Techniques for reducing stress and anxiety through meditation, yoga, and relaxation exercises. • Emphasis on holistic well-being, self-care, and community connection. • Supportive atmosphere and practical resources, including free childcare and workshops.	• More activities focused on physical and mental wellness, like yoga and extended meditation. • More frequent and diverse classes, workshops, and additional support services. • More comfortable venue and better promotion to make more people aware of the program.

NETWORK EXPANSION GRANTS PROGRAM
OTHER PEI PROGRAMS

Conclusions and Recommendations

Oxnard Performing Arts Center and Women of Substance Men of Honor NEGP programs have shown positive strides in reducing stigma around mental health support and connecting underserved Ventura County populations to wellness resources. Programs provided meaningful mental wellness activities, community connection, and skill-building opportunities for populations with historically limited access to mental health care. These programs effectively utilized culturally relevant, arts-based, and experiential approaches to engage Latino youth, BIPOC communities, and formerly incarcerated individuals.

To build on the success of the NEGP initiatives, it is recommended that future grantees receive support in establishing standardized data collection practices, including the use of retrospective pre/post measures and demographic tracking. Expanding promotional efforts, as suggested by participant feedback, could increase program visibility and accessibility, reaching a broader audience. Additionally, incorporating more frequent and diverse wellness activities tailored to community needs, such as extended meditation and physical wellness classes, would enhance engagement and encourage sustainable mental health practices among participants. These strategies can strengthen the NEGP's impact and support long-term mental health equity in Ventura County.

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RAPID INTEGRATED SUPPORT & ENGAGEMENT (RISE)
Ventura County Behavioral Health (VCBH)

Ventura County Behavioral Health offers the Rapid Integrated Support & Engagement (RISE) program specifically to encourage and allow people with mental health needs to get assessments and treatment. A field-based outreach team contacts individuals and then provides ongoing support in navigating any challenges to accessing care. The RISE team also follows up with clients as needed and may be closely involved with case management. The RISE program was discontinued as a Prevention and Early Intervention program in FY 23-24 and data is not reported. It was previously funded with Community Services and Supports (CSS) Outreach and Engagement dollars as well as PEI dollars, and now it is wholly funded with CSS dollars.

Program Strategies

Provides access and linkages to services through screenings and referrals to appropriate treatment.

Improves timely access to services for underserved populations, particularly people without access to services, by providing services in the field.

Program Highlights†

†Number of individuals may be duplicated.

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RAPID INTEGRATED SUPPORT & ENGAGEMENT

Demographic Data

RISE collects unduplicated demographic data from the individuals they serve. This section presents information from 1,777 individuals who completed a demographic form in FYs 21-22 and 22-23.

Demographic Category	FY 21-22	FY 22-23
Race*	**n = 694**	**n = 1,039**
American Indian/Alaska Native	1%	0%
Asian	1%	1%
Black/African American	4%	4%
Native Hawaiian/Other Pacific Islander	0%	0%
White	50%	44%
More Than One Race	0%	0%
Other	44%	51%
Ethnicity*	**n = 606**	**n = 771**
Hispanic/Latino		
Caribbean	0%	0%
Central American	0%	0%
Mexican/Mex.-Am./Chicano	36%	35%
Puerto Rican	1%	0%
South American	0%	0%
Other Hispanic/Latino	20%	18%
Non-Hispanic/Latino		
African	0%	0%
Asian Indian/South Asian	0%	0%
Cambodian	0%	0%
Chinese	0%	0%
Eastern European	0%	0%
European	0%	0%
Filipino	0%	0%
Japanese	0%	0%
Korean	0%	0%
Middle Eastern	0%	0%
Vietnamese	0%	0%
More than one	0%	0%
Other Non-Hispanic/Latino	43%	47%

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RAPID INTEGRATED SUPPORT & ENGAGEMENT

Demographic Category	FY 21-22	FY 22-23
Primary Language*	**n = 691**	**n = 1,059**
English	90%	90%
Spanish	9%	9%
Other	1%	1%
Age Groups	**n = 699**	**n = 1,078**
0-15 years	14%	8%
16-25 years	27%	21%
26-59 years	50%	57%
60+ years	9%	14%
Sex Assigned at Birth	**n = 694**	**n = 1,076**
Male	48%	51%
Female	52%	49%
Sexual Orientation	**n = 115**	**n = 87**
Heterosexual or Straight	88%	91%
Bisexual	7%	5%
Gay or Lesbian	5%	3%
Queer	0%	0%
Questioning or Unsure	0%	1%
Another Sexual Orientation	0%	<1%

*Total may exceed 100% because participants could choose multiple response options.

Note: Hispanic/Latino is not considered a race, but rather, an ethnicity according to State guidelines, therefore was not provided as an option.

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RAPID INTEGRATED SUPPORT & ENGAGEMENT

Program Activities & Outreach

RISE provides a range of program activities including crisis intervention, mental and behavioral health assessments, case management, and long-term plan development. The table below summarizes the number of activities by type that occurred in FYs 21-22 and 22-23.

Activity Type	FY 21-22	FY 22-23
Assessments	705	342
Case Management	2,627	3,604
Collateral Meetings	69	145
Crisis Intervention	3	10
Intensive Care Coordination	1	-
Interpretation	1	-
Mental Health Evaluation and Management	63	285
Medication Management	21	3
Plan Development	50	98
No Show/Outreach	136	152
Paperwork Completion	888	2,321
Transportation/Travel Services	68	156
Rehab Services	-	5
Other	43	-
Total Activities	**4,675**	**7,121**

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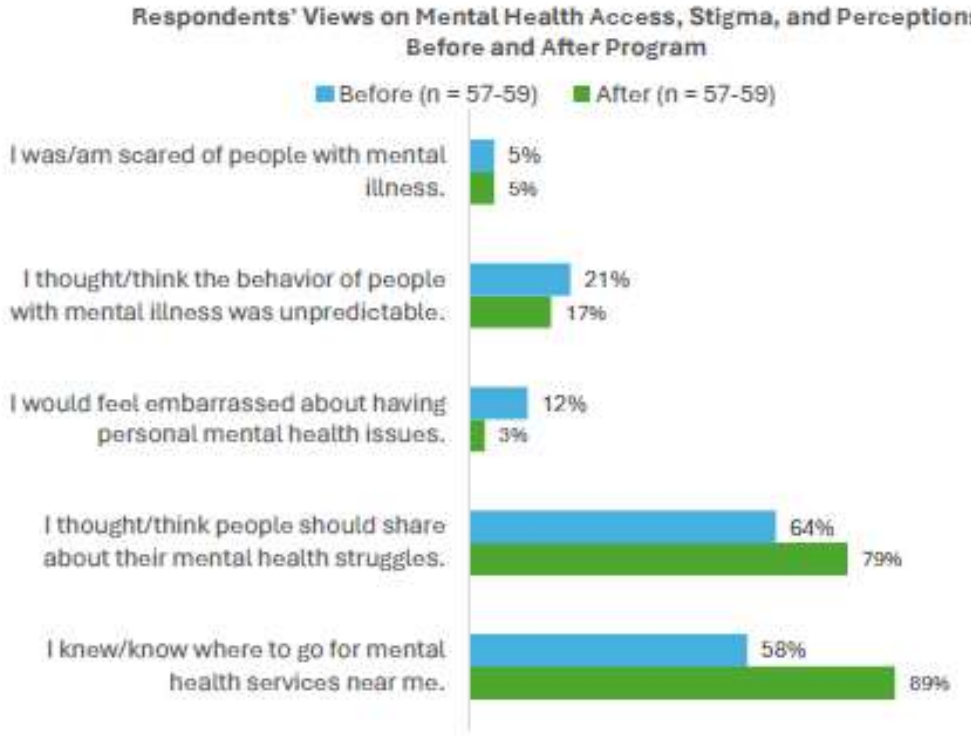
RAPID INTEGRATED SUPPORT & ENGAGEMENT

Program Outcomes

RISE tracks outcomes for program participants (i.e., those who receive services) by asking participants to self-assess their knowledge from two perspectives (retrospective pre/post): before and after they receive services. In FY 21-22, participants reported an average difference of 11% in knowledge after receiving services compared to before. Revisions to the data tool were made after FY21-22, and results for FY 22-23 are presented in the charts below.



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RAPID INTEGRATED SUPPORT & ENGAGEMENT

Program Satisfaction

To measure their satisfaction, participants were asked to indicate how much they disagreed or agreed with several statements about the RISE program. The percentages of participants who agreed or strongly agreed with each statement in FYs 21-22 and 22-23 are shown in the chart below.

Most participants were *highly satisfied* with the RISE program.

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RAPID INTEGRATED SUPPORT & ENGAGEMENT

Areas of Support

Participants were asked to select areas where they needed additional support from a list of options. The chart below highlights the top support areas identified in FYs 21-22 and 22-23. These insights can guide the program in enhancing services for the upcoming fiscal year.

FY21-22 (n = 37)

- Relationships with friends and family: **41%**
- Mental health: **19%**
- Job: **16%**

FY22-23 (n = 33)

- Relationships with friends and family: **24%**
- Mental health: **21%**
- Grades in school: **18%**

*Percentages may exceed 100% because participants could choose more than one response option.

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RAPID INTEGRATED SUPPORT & ENGAGEMENT

Conclusions and Recommendations

RISE aims to improve access to mental health services through field-based outreach, ongoing support, and follow-up. The program's activity data underscores the team's active engagement in case management, assessments, and paperwork completion, all essential for reducing mental health care access barriers.

From an outcome perspective, the RISE program has positively impacted participant knowledge and satisfaction, as indicated by the increased self-assessed expertise and high levels of participant satisfaction over time. To further strengthen the program, it is recommended that RISE standardize its activity reporting across all fiscal years to facilitate a more consistent analysis of program trends and outcomes. Additionally, targeted outreach efforts could enhance the involvement of other underrepresented demographic groups, who remain a smaller proportion of the participant pool. Addressing these areas could enable RISE to maximize its impact, extend its reach, and ensure that resources are directed toward the most needed and impactful services.

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SUICIDE PREVENTION EFFORTS & EVENTS
VENTURA COUNTY BEHAVIORAL HEALTH

Ventura County Behavioral Health (VCBH)'s Suicide Prevention Efforts and Events support community outreach, education, and intervention through the VCBH Suicide Prevention Council, Access/Crisis Line, in-person presentations/trainings, webinars, resource tabling, e-newsletters, STAY suicide prevention public service campaign, community events, and collaboration with local stakeholders.

Program Goals

Enhance interagency and community collaboration to identify, develop, and implement effective suicide prevention strategies

Increase knowledge and awareness of suicide risks and resources

Program Highlights

VENTURA COUNTY BEHAVIORAL HEALTH
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SUICIDE PREVENTION EFFORTS & EVENTS VENTURA COUNTY BEHAVIORAL HEALTH

Demographic Data

Suicide Prevention collects unduplicated demographic data from the individuals they serve. This section presents information from individuals who completed demographic forms over the past three years.

Demographic Category*	FY 21-22	FY 22-23	FY 23-24
Race*	**n = 65**	**n = 240**	**n = 12**
American Indian/Alaska Native	0%	1%	0%
Asian	2%	10%	8%
Black/African American	2%	1%	-
Hispanic/Latino	77%	55%	67%
Mixteco or other Indigenous	5%	9%	0%
Native Hawaiian, other Pacific Islander	-	-	-
White	15%	18%	8%
More Than One Race	-	7%	8%
Other	0%	2%	8%
Primary Language	**n = 51**	**n = 37**	**n/a**
English	94%	86%	-
Spanish	6%	11%	-
Indigenous (Mixtec or other)	-	-	-
Another Language	-	3%	-
Age Groups•	**N=35**	**n = 237**	**n=10**
0-15 years	6%	13%	0%
16-25 years	29%	57%	10%
26-59 years	51%	27%	60%
60+ years	14%	3%	30%
Gender Identity*	**n = 85**	**n =236**	**n = 13**
Male	12%	21%	-
Female	88%	75%	100%
Transgender	-	<1%	-
Genderqueer	-	1%	-
Questioning or Unsure	-	-	-
Another Gender Identity	<1%	3%	-

*Total may exceed 100% because participants could choose multiple response options.
* Ethnicity, sex assigned at birth, sexual orientation, disability and veteran status data not collected.
•Age group data for FY 22-23 represents two events. In FY 21-21, the average age was 35 years. In FY 23-24, the average age was 48 years.

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SUICIDE PREVENTION EFFORTS & EVENTS VENTURA COUNTY BEHAVIORAL HEALTH

Program Activities

Community Events

Suicide Prevention provides events for community members focused on raising awareness about suicide prevention, local resources, and mental well-being. Suicide Prevention has partnered with key stakeholders, such as the American Foundation for Suicide Prevention, 988, and MHSOAC, among others, for resource tabling, community presentations, prevention walks, and a Suicide Fatality Review Process. The table below lists community events and the number of individuals who participated over the past three years.

Activity Type & Participants	FY 21-22	FY 22-23	FY 23-24
Annual Suicide Prevention Forum	188	200	200+
Empower Up Transitional Age Youth Wellness Fair	130	400	n/a
Total Participants	**318**	**600**	**200+**

Community Event Satisfaction

Participants in Suicide Prevention community events were asked to rate various aspects of the events on a scale of "Very Good" to "Very Poor". The chart below shows the percentage of participants who responded "Good" or "Very Good" for each event component over the past three years.

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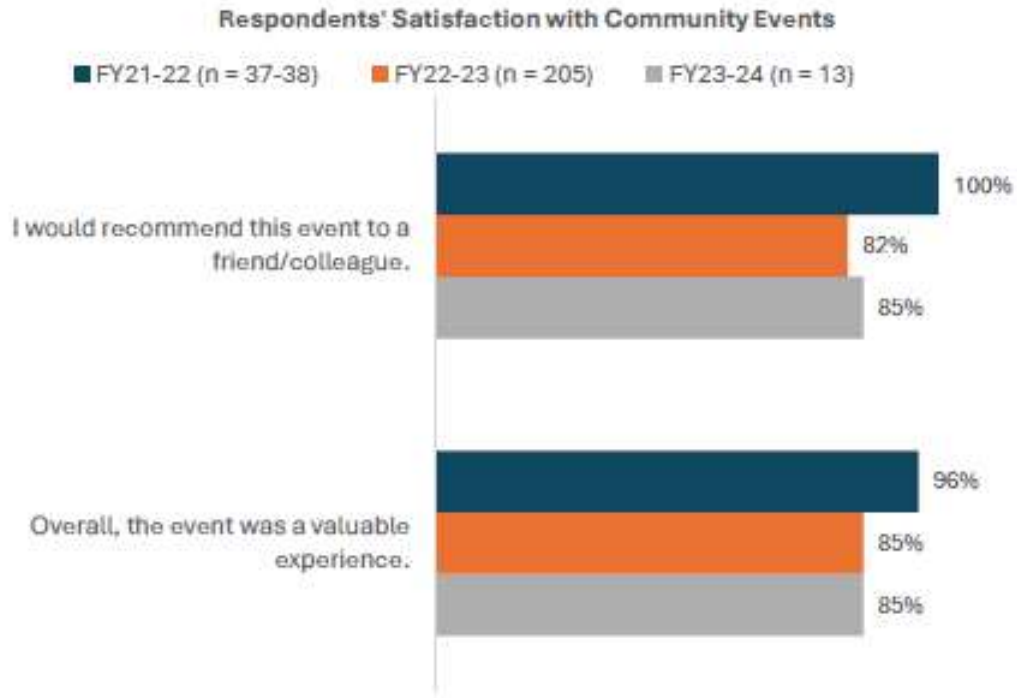
SUICIDE PREVENTION EFFORTS & EVENTS
VENTURA COUNTY BEHAVIORAL HEALTH

Participants in Suicide Prevention community events were asked to indicate the extent to which they agreed or disagreed with two satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement over the past three years.



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SUICIDE PREVENTION EFFORTS & EVENTS VENTURA COUNTY BEHAVIORAL HEALTH

Program Activities

Suicide Prevention Council

The Suicide Prevention Council, made up of stakeholders from across Ventura County, is committed to reducing suicides. The council's mission is to offer support and hope to those at risk or impacted by suicide by raising public awareness, identifying resources, providing education, and promoting innovative prevention and intervention efforts.

During FY 2023-2024, the Council met regularly, with an average of 25 attendees. Meetings included updates on Council activities, announcements from local organizations (e.g., upcoming events, volunteer opportunities, workshops, etc.), and educational presentations. Below is a summary of all presentations shared.

Guest Speaker	Presentation
Carly Memoli ***Learning Collaborative Consultant, Striving for Zero*** **Nicolle Perras, LMFT, MPH** ***Learning Collaborative Consultant, Striving for Zero*** **Noah J. Whitaker, MBA** ***Learning Collaborative Consultant, Striving for Zero***	08/02/2023 Interactive workgroup seeking community feedback in the development of the VCBH Suicide Prevention Council's Strategic Plan. Evidence for effective suicide prevention practices is growing every day. Following a public health model guided by data and community input, strategic planning helps to determine specific problems, identify prevention activities, and prioritize efforts to reduce deaths by suicide.
Andrea Guzman ***Programs Manager, Greater Los Angeles and Central Coast Chapter of American Foundation of Suicide Prevention***	10/04/2023 "Talk Saves Lives: An Introduction to Suicide Prevention" – Overview of common risk factors and warning signs associated with suicide, and strategies for keeping individuals safe.
James Espinoza, MS, RBLP-T ***President & Co-Founder of The Veteran Mentor Project, Inc.***	12/13/2023 Supporting veterans and first responders adjusting to life after service to reduce the risk of suicide and substance use and ensure fewer individuals slip through the cracks between systems of care.
Heidi Allison, LCSW ***Program Director & Co-Founder of Nate's Place, A Wellness and Recovery Center***	04/10/24 Peer support and Dialectical Behavioral Therapy (DBT) as an approach to supporting youth at risk for or experiencing substance use and mental health disorders.

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Guest Speaker	Presentation
Tess Allen ***Executive Director, Diversity Collective*** **Edgar Euan** ***Community Outreach Manager, Diversity Collective*** **Kate English** ***Diversity, Equity & Inclusion Manager, Youth Equity for Ventura County Executive Office*** **Smirthi Ram** ***Education and Training Coordinator, The Coalition for Family Harmony***	06/12/2024 Preventing Suicide in LGBTQIA+ communities. An Introductory Guide to P.R.I.D.E (Parent & Professional Responsibly for Inclusion, Diversity & Equity), an LGBTQ Cultural Competency Training was given. Resources, statistics, updates on the LGBTQIA+ Suicide Prevention Task Force, and registration information for the Bridging Families: LGBTQ+ Latino Wellness Event.

One of the Suicide Prevention Council's major achievements is the release of the Ventura County Suicide Prevention Strategic Plan for 2023-2028. The plan was created by a Council subcommittee with valuable input from diverse stakeholders and community members.

The plan serves as a roadmap to support and guide the collective efforts of individuals, families, and organizations in Ventura County that are dedicated to preventing suicide.

For more information about the Council and to stay connected with VCBH Suicide Prevention Efforts & Events please visit: wellnessforeveryday.org

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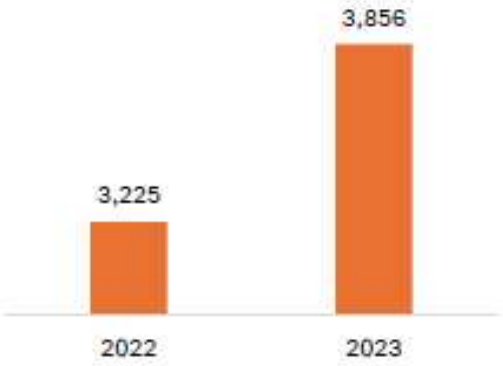
SUICIDE PREVENTION EFFORTS & EVENTS VENTURA COUNTY BEHAVIORAL HEALTH

988 Suicide & Crisis Lifeline

The 988 Suicide & Crisis Lifeline is a free, confidential, and multilingual resource available to anyone in distress*. Trained crisis counselors are available 24/7 to provide immediate emotional support through phone calls, text messages, and online chats for Ventura County residents. They also assist in connecting individuals at risk of suicide to local mental health resources and services. The information below highlights the number of contacts (calls, texts, and chats) originating from Ventura County over the past two years.

988 SUICIDE & CRISIS LIFELINE

2022-2023 988 Suicide & Crisis Lifeline Contact Volume



The 988 Suicide & Crisis Lifeline is an expansive network of over 200 crisis contact centers across the United States. Didi Hirsch Mental Health Services is the 988 crisis contact center for Ventura County, partnering with the VCBH Crisis Team for warm handoffs when indicated.

Suicide Prevention Newsletter

The Suicide Prevention E-Newsletter provides programming updates, helpful coping strategies, support resources, wellness events, and more. First launched in FY 2023-2024, the newsletter had 716 active subscribers, including representatives from County agencies, community organizations, care providers, and other key stakeholders.

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SUICIDE PREVENTION EFFORTS & EVENTS VENTURA COUNTY BEHAVIORAL HEALTH

Conclusions and Recommendations

The VCBH Suicide Prevention Efforts and Events demonstrate a commitment to addressing suicide through a multi-faceted approach, engaging stakeholders and delivering resources across the county.

With the release of the 2023-2028 Suicide Prevention Strategic Plan, VCBH and the Suicide Prevention Council are setting a structured path toward reducing suicides, which includes identifying priority populations, mapping local trends in suicide ideation and behaviors, and outlining strategies for prevention, intervention, and postvention. These efforts reflect a focused and collaborative approach to suicide prevention, promoting awareness, education, and innovative interventions that are essential for tackling the complex issue of suicide in diverse communities. Facilitating Council Implementation Workgroups will continue moving the plan's goals and aims forward.

Community events created engaging spaces for over 1,100 youth and adults to discuss mental well-being, local resources, and tailored support for specific populations. Positive feedback from respondents highlights the events' value, supporting the need for more gatherings across the County to boost community awareness and knowledge on critical topics in suicide prevention. Hosting In-person evidence-based suicide prevention gatekeeper training can help community members feel more confident in responding to someone experiencing suicidal thoughts.

Ongoing activities, such as the VCBH Suicide Prevention Council's hybrid meetings, further strengthen community understanding and awareness of key topics. With an average of 25 engaged attendees, these meetings provide critical networking and educational opportunities and help promote local initiatives that align with the Council's mission.

The 988 Suicide & Crisis Lifeline remains a cornerstone resource, offering 24/7 multilingual crisis support and linking individuals in distress to mental health services. The increase in the Lifeline's contact volume, from 3,225 in 2022 to 3,856 in 2023, indicates a growing reliance on and awareness of this critical resource within the community. This uptick suggests that outreach efforts and community education will likely contribute to more individuals recognizing and utilizing available support when in distress. It also highlights the importance of maintaining and potentially expanding hotline resources to meet the increasing demand, ensuring that all calls, texts, and chats are handled efficiently. Enhanced tracking and analysis of hotline data could further inform VCBH on specific needs within Ventura County, enabling targeted outreach to at-risk populations and reinforcing the hotline's role as a preventive measure against suicide. Creating a Suicide Fatality Review Team with partnering agencies would be beneficial to inform suicide prevention efforts and decrease suicide risk in the community.

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APPENDIX A. CATEGORIES OF VCBH PEI PROGRAMS

Program	PEI Program Categories						
	Prevention	Early Intervention	Outreach for Increasing Recognition of Early Signs of Mental Illness	Stigma & Discrimination Reduction	Access and Linkage to Treatment	Suicide Prevention*	Improving Timely Access to Services for Under-served Populations*
Multi-Tiered System of Support Ventura County Office of Education							
Wellness Centers Expansion Ventura County Office of Education							
One Step a La Vez							
Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) County of Ventura Human Service Agency Area on Aging (HSA)							
Project Esperanza Our Lady of Guadalupe Church							
Promoviendo Program Promotoras y Promotores Foundation (PYPF)							
Healing the Community Mixteco Indigena Community Organization Project (MICOP)							
Tri-County GLAD							
Wellness Everyday and STAY Media Campaign Idea Engineering, Inc							
Ignite Catalyst Church							
Network Expansion Grants Program Prevention							
COMPASS Seneca Family of Agencies							
Primary Care Program Clinicas del Camino Real, Inc.							
Ventura County Power Over Psychosis (VCPOP)							
Network Expansion Grants Program Early Intervention							
Crisis Intervention Team (CIT) Ventura County Law Enforcement							
Diversity Collective							
Logrando Bienestar							
Rapid Integrated Support & Engagement (RISE)							
Suicide Prevention							
Network Expansion Grants Program Other PEI							

*Optional program category according to PEI regulations.

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APPENDIX B. FY 21-22, 22–23, 23-24 NUMBERS SERVED

FY 21-22, 22–23, 23-24 Number of Participants Served by Program and Category

	FY21-22	FY22-23	FY23-24
Prevention Programs	**n=184,782**	**n=254,601**	**n=254,601**
Ignite Conocimiento	--	--	93
Mixteco Indigena Community Organizing Project (MICOP)	148	143	140
Multi-Tiered System of Support (MTSS) – LEA and VCOE	162,684	203,465	252,656
Network Expansion Grants – Prevention Programs	--	29	256
One Step a La Vez	209	110	241
Program to Encourage Active, Rewarding Lives for Seniors	241	184	225
Project Esperanza	219	110	122
Promotoras y Promotores Foundation (PYPF)	129	145	207
Tri-County GLAD	31	41	42
Wellness Centers Expansion	--	25,233	89,868
Wellness Everyday and STAY Media Campaign	21,121	25,141	44,115
Early Intervention	**n=664**	**n=634**	**n=656**
COMPASS	12	15	18
Network Expansion Grants – Early Intervention Programs	--	--	61
Primary Care Program Clinicas del Camino Real, Inc.	399	348	305
Ventura County Power Over Psychosis (VCPOP)	253	271	272
Other PEI Programs	**n=2,515**	**n=6,697**	**n=6,323**
Crisis Intervention Team	89	99	96
Diversity Collective*	39	212	235
La CLAve Education and Training	33	--	--
Logrando Bienestar	1,655	1,279	1,777
Network Expansion Grants – Other PEI Programs	--	29	215
Rapid Integrated Support & Engagement	699	1,078	--
Suicide Prevention	--	4,000	4,000

*In the FY21-22 annual report, Diversity Collective was reported in Prevention Programs.

FY 21-22, 22–23, 23-24 Number of Participants Served by City of Residence[5]

	FY21-22		FY22-23		FY23-24	
City	n = 3,954	%	n = 2,752	%	n = 1,196	%
Camarillo	140	4%	134	5%	28	2%
Fillmore	257	6%	186	7%	268	22%
Moorpark	86	2%	47	2%	5	0%
Newbury Park	28	1%	48	2%	2	0%
Oak Park	2	0%	8	<1%	1	0%
Ojai	33	1%	40	2%	10	1%
Oxnard	1,804	46%	733	27%	357	30%
Piru	25	1%	8	<1%	7	1%
Port Hueneme	96	2%	67	2%	25	2%
Santa Paula	617	16%	351	13%	358	30%
Simi Valley	208	5%	187	7%	24	2%
Thousand Oaks	144	4%	109	4%	19	2%
Ventura	415	10%	408	15%	90	8%
Other	99	3%	426	16%	2	0%

[5]City of residence data is not available for Crisis Intervention Training, Logrando Bienestar, Multi-Tiered System of Support VCOE, Multi-Tiered System of Support LEA, Wellness Centers, and Wellness Everyday.

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Appendix D: VCBH NEG FG Summary

Ventura County Behavioral Health FY 23-24

Advancing Collective Impact Through the Network Expansion Grants

COMMUNITY NETWORK EXPANSION GRANTS OVERVIEW

Learning about the community is keeping people well.

In the Spring of 2023, Ventura County Behavioral Health planned to support the concept that hundreds of people in Ventura County are getting their wellness needs met through their natural networks of family, friends, faith groups, and community groups, and are not accessing local government for mental health service needs.

Ventura County wanted to recognize these natural networks and provide funding for the contribution community makes in keeping people well. The goal was to learn from and build upon what these natural networks can provide.

The program ran from May 12, 2023, through June 30, 2024, in which 20 grantees were awarded serving 532 people. Target populations included Black, Indigenous, and People of Color (BIPOC), disabled people, justice-involved, Latinx, LGBTQ+, older adults, transitional age youth (TAY), and youth.

PURPOSE

This report presents findings from two focus groups conducted in the Spring of 2024 with Network Expansion Grants recipients. These grants have played a vital role in supporting innovative, community-centered projects to promote wellness and equity among Ventura County residents.

The focus groups sought to explore grantees' experiences with the NEG program, examining its contributions to advancing equity, fostering collaboration, building trust, and strengthening community integration. By gathering and analyzing grantees' perspectives, this report provides valuable insights into the program's effectiveness and collective impact.

FINDINGS

Engagement and Inclusivity

Success is achieved by including diverse voices, building trust, and ensuring everyone has the opportunity to participate. The NEGs have created pathways for marginalized individuals by fostering access, encouraging participation, and nurturing a sense of belonging through strategies such as:

- Providing transportation assistance.
- Providing opportunities to engage in new and meaningful activities, from rock climbing to access to state-of-the-art equipment for music production.
- Creating safe spaces for identity exploration.
- Addressing cultural and language barriers with culturally competent staff.
- Tailoring approaches to maintain long-term engagement, such as using social media, messaging apps, and other platforms popular among youth today

> *We bought a van last summer... We're now doing about 60 pickups a week!*

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Collaboration and Impact

Investments in community programming have strengthened networking opportunities for NEG grantees, fostering meaningful partnerships that address critical community needs through innovative and inclusive approaches.

Building Collaborative Partnerships

Grantees partnered with schools, nonprofits, and local organizations to expand access to services and provide diverse educational and recreational opportunities. For example, a partnership with an outdoor organization offered youth confidence-building activities like rock climbing and hiking, while collaborations with local high schools launched four-week prevention counseling groups for students.

Addressing Community Needs Through Joint Efforts

Grantees collaborated with other organizations to tackle pressing community challenges, creating programs like a safe space for youth facing bullying and a specialized initiative for older adults with autism. These joint efforts ensured targeted support for underserved groups and fostered inclusivity.

Expanding Community Impact

By leveraging expertise and aligning with community strengths, grantees broadened their reach. Key initiatives included co-branded educational materials, community training sessions, and outreach in trusted spaces like churches and schools, increasing awareness and participation.

> *Whether it was an entrepreneurship or STEM-based confidence-building program or a graffiti art program, [the collaboration] allowed us to link some of the youth we work with.*

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Communication and Trust Building

Effective communication strategies are essential for building trust and fostering strong relationships with community members. By employing multimodal approaches and facilitating peer-to-peer connections, grantees successfully engaged diverse populations and strengthened bonds within their communities.

Multimodal Communication to Meet Diverse Needs

Key Practices:

- Simplifying materials for participants with lower literacy levels to foster participation.
- Sending frequent, timely reminders via text or email to ensure attendance.
- Providing questions in advance to reduce anxiety and encourage thoughtful responses.
- Pre-prepping participants with prompts to create structured and comfortable engagement.
- Designing intimate, small-group settings to create safe spaces for expression.

Facilitated Peer-to-Peer Communication and Emotional Connection

Key Practices:

- Hosting reflective group activities where participants shared positive feedback.
- Encouraging emotional expression through prompts from books and external sources.
- Creating opportunities for participants to present their learnings to parents, fostering confidence and community pride.

"The kids need to hear it from each other, not just another adult; they value peer feedback more. We now have seven peer coaches, participants connect more oftentimes."

"Texting works with young people and even with parents... We had a specific person reaching out to parents before each session."

Backbone Coordination

Tailored support and culturally sensitive strategies are key to bridging service needs, facilitating processes, and building strong community connections. Programs under the NEGs initiative contributed to addressed community needs in mental health, family support, and interpersonal engagement through innovative and inclusive approaches.

Addressing Services Needs in Mental Health and Family Support	Providing relatable, non-clinical support through peer coaches with shared experiences.	Offering free, day-long structured programs to keep youth engaged and supported.	Including parents in program activities to strengthen family dynamics and ensure skills learned are practiced at home.
Promoting Face-to-Face Connections and Reducing Technology Dependency	Encouraging youth to build interpersonal connections through activities like writing personal notes.	Facilitating in-person group projects to strengthen bonds and emotional engagement.	Encouraging extended periods without technology to focus on meaningful, real-world interactions.
Bridging Cultural and Generational Gaps in Access to Services	Ensuring monolingual Spanish-speaking families received program information in their language.	Addressing the unique challenges of single parents and families dealing with mental health stigma.	Designing programs that aligned with community traditions to encourage participation and trust.

Building Bridges

The NEGs process has been a journey of collaboration, adaptability, and meaningful impact, from grant application to activity implementation. Grantees reflected on Ventura County Behavioral Health (VCBH) 's critical role in ensuring their programs thrived, providing essential support, fostering trust, and enabling innovation.

- **Strengthening Organizational Foundations**

  For many grantees, VCBH's guidance during the grant process was instrumental in building organizational capacity. Grantees highlighted that from the outset, VCBH set clear expectations for invoicing, reporting, and data collection, which helped even those new to grant management feel confident navigating the process. Some noted that these clear and consistent communication practices empowered them to adopt stronger internal processes, many of which extended beyond the immediate scope of the grant.

- **Collaborative Flexibility in Action**

  VCBH's responsiveness and flexibility became a cornerstone of the grant's success. Grantees consistently highlighted how the county worked to meet them halfway, addressing challenges in real time while maintaining a supportive environment. This adaptability created a space where grantees could focus on program execution without the stress of rigid or burdensome requirements.

- **Expanding Impact Through Operational Innovation**

  Beyond foundational and logistical support, grantees shared how VCBH's funding flexibility enabled programs to enhance their impact in creative and meaningful ways. Many grantees utilized these funds to add new elements that enriched the participant experience, such as incorporating meals into their programs. These simple additions encouraged deeper interpersonal connections, creating opportunities for conversation and community-building.

> *It was always a collaborative process of 'Let's work through that,' which made it feel like we weren't alone.*

CONCLUSIONS

The Network Expansion Grants have successfully embodied the principles of collective impact by fostering collaboration, building trust, and creating pathways for historically marginalized communities to thrive. Through the combination of strategic partnerships, responsive leadership, and innovative, community-centered approaches, the NEGs have strengthened organizational foundations, expanded community engagement, and increased access to critical services. Ventura County Behavioral Health's essential support has played a pivotal role in this journey, creating an environment where grantees can innovate and effectively address the evolving needs of the community. The NEGs continue to be a powerful force for equity and wellness, paving the way for sustainable, long-term positive change.

NETWORK EXPANSION GRANTEES

Amplify Arts Project Girls Rock SB hosted girls and gender-expansive youth in grades 6 to 12 for a weekend centered around exploring their identities, interests, and well-being through music, creative arts, and mentorship. Through various artistic workshops and wellness activities, youth cultivated technical art skills, connections with peers, empathy, and self-discovery.

Autism Society Ventura County held a bi-monthly book club and writing workshop for disabled and neurodivergent adults, families, and caretakers. The workshop enabled participants to tell their stories in their own words and discuss literature related to disability. Program participants developed a sense of community, improved confidence and mental health, and were exposed to literature centering authors and characters reflective of themselves.

Big Brothers Big Sisters of Ventura County's "Team: Changing Minds VC" program expanded professional case management services to gaming and social media environments for youth aged 12-17 years who identified as Black, Indigenous, or People of Color (BIPOC) and were struggling with mental health needs. Their case managers and volunteer mentors engaged youth through networked gaming such as Minecraft or Words with Friends in at least 50% of their interactions. This innovative approach to support networks led to improved communication, including disclosing different topics and new adversities and stronger bonds with agency professionals and mentors.

Boys & Girls Club of Greater Oxnard & Port Hueneme engaged underserved youths aged 6-18 in the Be Kind Program. Some workshop topics were on developing the value, impact and importance of kindness; understanding respect, empathy, and consideration; developing strategies to understand their thoughts and emotions; and understanding the power of being present in the moment. Participants received materials to continue these practices and build upon learned skills, as well as resources and linkages for mental health wellness.

Candela Group conducted a Mental Health Workshop Series which provided workshops over ten weeks among family members and/or individuals affected by serious mental health challenges. The program was offered both in-person and virtually to accommodate the needs of the community members. Each week the participants were introduced to, guided through, and encouraged to share their experiences on a particular topic. A client reference binder was also built throughout the weeks and remained with the participant to be updated and referred to when engaging with service providers.

Childhood Matters established child-centered, safe spaces in the Ventura County Courthouse equipped with tools and materials to help all children, especially those who were victims of domestic abuse, manage their emotions, self-regulate, and build coping skills. These spaces allowed children to rest and shifted their focus from the experiences that brought them to the courthouse. Adults, including courthouse staff, parents or guardians, were also offered resources for learning how to ensure children have the skills needed to manage their behavior and trauma effectively.

De Colores Multicultural Folk Arts, Inc. engaged older adults and youth, often grandparents and their grandchildren, in intergenerational multimedia art classes over 10 weeks to foster confidence, social connections, and community well-being. At a community reception, program participants showcased their completed projects, ranging from paintings to sculptures.

LUCHA (Fiscal Agent for Poder Popular) (grant incomplete) would have targeted residents of Santa Paula, CA, who were farmworkers, seniors, LGBTQ+ individuals, youth, immigrants, low-income, unhoused, and members of other marginalized groups for the Adelante project. The project consisted of providing monthly Community Engagement Events to promote mental health wellness through cultural enrichment activities to local marginalized populations

within a social safety net support system that helped stabilize and motivate residents to advocate for themselves, their families, and their neighborhoods.

Mesa Yoga developed a pilot program, Empowering At-Risk Young Adults through Trauma-Informed Therapeutic Yoga (Yoga Therapy). The program goal was for participants to improve self-regulatory behavior and enhance overall well-being while reducing adverse health outcomes. The program was offered free of charge and targeted young adults ages 18-24 who were at risk of declining well-being.

NAMBA Rock and Roll High provided a space for creative expression to students aged 12-18 in underserved areas of Ventura through a one-week intensive, high-quality music education course. Students learned musical instruments, vocals, songwriting, and more before performing their original songs live at the end of the program.

Nate's Place, A Wellness and Recovery Center implemented a new pilot program called Nate's Place that targeted low-to-middle-income teens and young adults who may have been experiencing mental health conditions and/or experiencing a substance use disorder. At least 80% of the program participants was from the Latino, BIPOC, and LGBTQ+ communities. It included 1:1 peer support recovery coaching and group outdoor activities such as hiking, rock climbing, boating, fishing, outdoor meditation, yoga, and other excursions led by peer coaches and specialists.

National Health Foundation (Fiscal Agent for FIND – Friend in Deed) (grant incomplete) was a program that intended to offer three support groups and target those who were 1) personally considering or have considered issues related to death by suicide; 2) parenting while dealing with their own mild to moderate mental health challenges; and 3) any community member who was curious to learn about alternative frameworks for supporting people with distressing behaviors or thoughts.

No Limits for Deaf Children and Families Community Careers provided knowledge, skills, and inspiration to deaf youth and their siblings through career exploration via hands-on curriculum and field trips. Youth were empowered to broaden their career horizons and confidently pursue any desired profession. Additionally, the program raised awareness about effective communication strategies with deaf individuals, fostering a more inclusive and informed community.

Nyeland Promise sought to reduce stress, anxiety, and depression for Latina women farm workers in Nyeland Acres by providing yoga, educational workshops, art classes and music. Program participants were able to engage in new experiences, like going to a movie theater and developing friendships with community peers. All participants reported feeling less lonely, depressed, and tense after partaking in the different activities offered.

Open Door Studio (grant incomplete) would have produced a one-month interactive and immersive exhibit, All the Feels Sensory Museum. They would have partnered with other organizations focused on mental health and wellness to serve underserved artists with autism and other neurodivergent disabilities in collaboration, design, and creation of the exhibit. It would have also served the entire community, as they could learn more about art, local mental health resources, inclusion, and living with a disability.

Oxnard Performing Arts Center Corporation (OPAC) presented the Art is Wellness Summer Club program consisting of wellness-related in-person and online activities aimed toward low-income, underserved Latino youth and families from Oxnard seeking mental wellness information and arts activities. The program included family-oriented sensorial experiences such as drum circles, dancing, and gardening, coupled with resource tables and displays containing mental health information and resources representing underserved populations. There was also a button-making station with mental health-related statements. For those unable to attend, OPAC dedicated a section of its website to mental health and created a series of easy-to-follow videos and art therapy-related activities.

Santa Paula Town Hall Adelante Project (grant incomplete) would have implemented the El Joven Noble program, which is a comprehensive indigenous-based youth leadership development program that supports and guides youths through the rights of passage process and focuses on the prevention of substance use disorder, teen pregnancy, relationship violence, gang violence, and school failure. The program engages participants in activities that impact their character, shape their development, and provides a positive impact through a culturally responsive scope of practice.

The Elite Theatre Company supported marginalized youth and young adults aged 15-25 to participate in theatre classes and staged productions in The Conservatory Project. The series also included mental health wellness classes covering different mental health topics. The provider used a mental health professional to train the teachers and mentors on mental health-related issues to develop the mental health wellness classes. The project focused on building individual empowerment, resiliency, and self-determination, as well as cultivating the development of transferable life skills and building strong interpersonal connections.

Two Trees Community implemented a prevention program, Paloma Youth, to help Latinas/Latinos ages 9-15 cope with suicidal ideation and prevent self-harm. The program consisted of support groups where youth could talk about problems among peers of similar backgrounds and focus on mindfulness practices, emotion regulation, interpersonal skills, and distress tolerance skills. Group therapy was based on Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT). CBT focuses on how thoughts and behaviors influence each other and is beneficial for anxiety and obsessive-compulsive disorders. DBT focuses on mindfulness practice and emotion regulation and is helpful for suicidal ideation and self-harm.

Ventura County Clergy and Laity United for Economic Justice (CLUE-VC) engaged 37 organizations to host a mental health and family wellness-focused resource fair, "Swap Meet Justice," at Oxnard College, reaching approximately 600 Hispanic/Latinos, immigrants, farm worker families, and monolingual Spanish- and Mixteco-speakers. Five workshops were also offered to participants covering topics like stress relief, early signs of mental health challenges, diabetes prevention, and first aid.

VC Family Justice Center Foundation developed Pathways of Hope, an equine-assisted psychotherapy program that helped youth ages 7-17 focus on their emotions and learn about wellness. All exercises were conducted on the ground and involved interacting with the horses through a variety of activities. The program targeted youth exposed to traumas, including domestic violence and sexual assault, and whose household income was less than $13,000 per year. By exploring and processing patterns externally through activities with horses, children learned to describe their emotions accurately, identify and correct their distortions, and develop more positive coping strategies to enhance their general functioning. These activities could promote change in thinking, which promotes behavior change.

Women of Substance, Men of Honor (WOSMOH) targeted current and former foster youth, juvenile justice-involved youth, and formerly incarcerated youths ages 18-28, including Latino, BIPOC, and other marginalized populations in the TAY HOPE (Transitional Age Youth Helping Our Population Excel) Wellness Events. The program included focus groups, resource fairs, and workshops to develop and distribute learning tools to build and manage the impact of unmet mental health needs.

Appendix E: FSP Multi-County INN Final Report

RAND CalMHSA

Evaluation Report

NICOLE K. EBERHART, J. SCOTT ASHWOOD, WENDY HAWKINS, ALISON ATHEY, STEPHANIE WILLIAMSON, ALEJANDRO ROA CONTRERAS, RYAN K. MCBAIN, STACEY YU, PRIYA GANDHI

Evaluation of the California Multi-County Full Service Partnership Innovation Project

Serious mental illness (SMI), as defined by the Substance Abuse and Mental Health Services Administration, pertains to individuals age 18 and older who either presently have or have experienced within the past year a diagnosable mental, behavioral, or emotional disorder leading to functional impairment that hinders or restricts major life activities.[1] In 2019, 3.9 percent of adults in California experienced an SMI,[2] with higher prevalence among Californians with the lowest incomes.[3] Beyond income, another barrier to sustained wellness and recovery for individuals with SMI is co-occurring substance use disorders, creating complex needs for treatment.

California's Full Service Partnership (FSP) programs aim to address these barriers. FSP programs began as an effort to provide comprehensive and integrated care for people with SMI with the goal of reducing hospitalizations, justice involvement, and homelessness.[4] FSP programs provide comprehensive, recovery-oriented services and share a philosophy of individualized care, often employing intensive case management or assertive community treatment, a community-based service delivery model for people living with severe and persistent mental illness.[5] Some of the FSP programs are directly

KEY FINDINGS

- The initial cohort of six counties participating in the California Multi-County Full Service Partnership (FSP) Innovation Project successfully developed standardized definitions for key populations served, as well as common process and outcome metrics. A subset of the counties succeeded in developing program step-down and graduation guidelines, improved data collection processes, and referral guidelines or processes.
- After the initial development of planned changes to the FSP programs, the extent of on-the-ground implementation and sustainment varied by county and by innovation area.
- Outcomes for FSP participants improved during the first 12 months of involvement. Participants experienced reduced psychiatric inpatient admissions, increased stable housing, and decreased judicial system involvement.
- Improvement in individuals' outcomes increased after participation in the FSP Innovation Project, suggesting that the project facilitated improved quality of care.

operated by counties, while many are provided by nonprofit human services organizations contracted by counties.

FSP programs are funded by the Mental Health Services Act (MHSA), enacted by California voters in 2004 and generated through a 1 percent tax on annual personal income exceeding $1 million. The MHSA seeks to enhance the state's behavioral health system. The MHSA uses a comprehensive approach to better serve individuals and families dealing with serious mental health issues.[6] Community Services and Support constitutes one of the five funding components of the MHSA and encompasses three service categories, one of which constitutes FSP programs.[7]

FSP programs first began as a result of advocacy efforts in California; in 1999, legislation passed to support four pilot projects that funded comprehensive and integrated care for individuals who were at high risk of becoming unhoused, involvement with the justice system, and hospitalization.[8] As of 2021, more than 60,000 individuals were enrolled in FSP programs throughout California, and FSP programs represented a $1 billion annual investment in public funds.[9] There are various types of FSP programs, and each is designed for different age groups and subpopulations, as determined by each county and contracted provider within the county. This approach results in wide variations among FSP program design and eligibility across the state. Typically, people who are eligible for FSP programs have an SMI, are unhoused or at risk of being unhoused, are involved or at risk of being involved with the criminal justice system, and have had frequent visits to the emergency department.[10]

Abbreviations

CalMHSA	California Mental Health Services Authority
CI	confidence interval
DBH	department of behavioral health
DCR	Data Collection and Reporting System
EHR	electronic health record
FSP	Full Service Partnership
KET	Key Event Tracker
MHSA	Mental Health Services Act
PAF	Partnership Assessment Form
SMI	serious mental illness

The fundamental principle of FSP programs is to do "whatever it takes" to partner with individuals on their paths to wellness or recovery. FSP programs can provide support beyond mental health services and integrated treatment; the programs can also assist with housing, employment, and education. FSP program services are designed to be as accessible as possible. They are culturally and linguistically appropriate, allow flexibility in terms of service delivery location (e.g., at home or in the community), and employ informal sources of care, such as peer and caregiver support groups. Some unique aspects of FSP programs are provider partnerships with participants and their families in the design of a treatment plan, a low staff-to-participant ratio, around-the-clock access to care, and a team-based approach that provides comprehensive and personalized care to each individual served.

In 2020, the Mental Health Services Oversight and Accountability Commission, the California Mental Health Services Authority (CalMHSA), and an initial group of six counties launched the California Multi-County FSP Innovation Project in partnership with Third Sector, a nonprofit organization that provides technical assistance to the public sector. In collaboration with Third Sector and one another, six counties established a collaboration model that fostered peer learning and county cooperation to enhance FSP programs. Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura counties initially participated in the project, with additional counties joining later. The FSP Innovation Project identified commonalities and differences among FSP programs and practices across counties to inform the design of FSP program innovations.

Third Sector conducted a landscape assessment to gather contextual information in 2020, then worked with the counties on implementation and sustainability of innovations in 2021. Overarching goals of the FSP Innovation Project were identifying a shared understanding of FSP's core components, improving consistency across FSP programs, and developing or enhancing operational processes that are data driven and outcome oriented. To this end,

Third Sector provided all participating counties with technical assistance in defining key populations and in tracking process and outcome measures and metrics. In addition to these two core innovations, counties chose which additional innovations to work on, according to their individual needs. To this end, Third Sector also provided technical assistance on other topics that varied by county—including defining eligibility for FSP program services, developing criteria to be used to establish that individuals maintained eligibility for services (i.e., the reauthorization process), improving data collection processes, and developing guidelines for enrolling individuals into FSP programs or referring them to other programs. Table 1 shows the types of innovations the counties chose to work on.

This report covers the original six counties, whose locations represent the major regions of California, from Siskiyou County on the northern border of the state to Ventura County and San Bernardino County in Southern California (Figure 1). The participating counties also represent the range of populations in the state, from rural (Siskiyou County) to urban (Sacramento County).

CalMHSA contracted with RAND to conduct an independent, objective evaluation of the Multi-County FSP Innovation Project. RAND is a nonprofit and nonpartisan policy research organization that has extensive experience evaluating California's mental health programs.[1] The RAND team's evaluation examined the period directly following innovation implementation at the end of 2021 through 2023. We conducted a mixed-methods evaluation, with qualitative and quantitative components. The qualitative evaluation collected and analyzed data from semistructured, qualitative interviews with representatives from the participating counties, including department of behavioral health (DBH) leadership, FSP program administrators, and FSP program providers. The interviews focused on the strengths and weaknesses of the FSP Innovation Project, any impacts interviewees noticed in their programs, challenges that arose during the FSP Innovation Project, perceived sustainability of the work, and lessons learned across the counties. The quantitative component analyzed electronic health records (EHRs) and program data to examine the impact of FSP programs on participant outcomes and whether this

TABLE 1
Innovation Activities

Innovation Activity	Definition	Number of Participating Counties
Defining key populations	Standardize the definition of key populations served by FSP programs (e.g., individuals experiencing homelessness)	6
Defining and tracking outcome and process metrics	Identify standardized measures and metrics for tracking what services individuals receive and key health outcomes	6
Step-down (graduation) guidelines	Define stability and recovery indicators as criteria for FSP program graduation	5
Service requirements	Develop minimum FSP program service requirements to adopt as official guidance	3
Reauthorization process	Standardize the processes for reauthorizing FSP program enrollment for those who do not meet step-down criteria	2
Eligibility guidelines	Revise county-specific eligibility guidelines for enrollment in FSP programs	2
Data collection processes	Streamline existing processes or develop new ways of collecting data that can inform care decisions	2
Referral guidelines	Create a standardized FSP program referral form that captures key data	1
Referral and enrollment processes	Create a specific referral and enrollment process for youth FSP programs	1

FIGURE 1
The Six Counties Participating in California's FSP Innovation Project

impact changed over time as a function of participating in the FSP Innovation Project. In this report, we present the evaluation methodology, key findings, and conclusions from qualitative and quantitative analyses, followed by an overarching conclusion.

Qualitative Evaluation: Findings from Interviews

Qualitative interviews were used to answer evaluation questions regarding the implementation and impact of the Multi-County FSP Innovation Project, including strengths and weaknesses, perceived effects, barriers and facilitators, and lessons learned. We also inquired about the sustainability of the changes implemented.

Methods

Sampling and Recruitment

RAND worked with county points of contact to identify potential participants in the qualitative interviews. We requested that these people provide contact information for two groups of individuals: (1) county DBH leadership (i.e., individuals who could speak to how the FSP Innovation Project changed practices and about the strengths and weaknesses of the project) and (2) contracted providers (i.e., individuals who could speak to the impact of the FSP Innovation Project on providers and potentially on individuals served). Points of contact were not given a specific number of individuals to identify in each category, as counties varied in terms of the number of individuals in each of these two roles.

A member of the evaluation team reached out to potential participants via email up to five times to try to schedule an interview. The RAND team conducted 31 semistructured qualitative interviews about the FSP Innovation Project. The qualitative interview sample included 31 completed interviews involving DBH leadership and administrators ($n = 14$) and FSP providers ($n = 17$) across the participating counties. The team interviewed between five and eight people from Fresno, Sacramento, Ventura, and Siskiyou counties, and the team spoke with one to four people from San Bernardino and San Mateo counties. An additional 18 key informants were contacted via email up to five times and did not respond to the interview request.

Measures and Metrics

The RAND evaluation team developed a semistructured interview protocol that guided our discussions with participants; it was based on key goals of the FSP Innovation Project, outlined in Table 1. Specifically, the interview protocol covered new activities and changes made as part of the FSP Innovation Project, the implementation process, and any impacts the changes had on staff and for the populations they serve. We also discussed challenges to implementation and lessons learned, sustainability of the new activities, and strengths and weaknesses of the FSP Innovation Project.

Procedures

All of our evaluation procedures were approved by RAND's Human Subjects Protection Committee. Before conducting interviews, we obtained verbal consent from our interviewees. All of our interviews were conducted virtually via Zoom for Government, which is a RAND-approved secure platform for conducting qualitative interviews. Interviewers also received verbal consent to audio record interviews for note-taking purposes. Interviewers took detailed notes during the interview in a Microsoft Excel abstraction form designed based on the interview questions in our interview protocol and then went back to listen to recorded interviews as necessary to fill in the matrix with any important missing details.

In cases in which interviewees asserted that no changes were made as a result of the FSP Innovation Project ($n = 2$), our protocol was to ask about each activity and change in the interview protocol to ensure that we were not missing important details. With these interviews, we noted that no new changes were reported as the outcome of the interview.

Data Analysis

To analyze the data, our team used the abstraction form described above to pull out recurring themes across the interviews. After each interview, the interviewer filled out the form with the respondent's

FSP programs should "foster independence and [help individuals served] connect to their community" so that those in the program can ultimately utilize "the lowest level of care possible: . . . [The project was] a reminder to everybody that that's what we're doing."

comments related to each topic covered. This method helped outline implementation changes across each county. The abstraction matrix also described implementation barriers and facilitators, the status of implementation changes, findings about sustainability of the changes, and opinions on the FSP Innovation Project overall. The RAND evaluation team used the abstraction spreadsheet for a rapid thematic analysis.[12] Each interviewee filled in their abstraction form, and one other interviewer read the notes to confirm interview results. Major findings were identified by RAND evaluators. Discussion among all team members was used to resolve disagreement about the findings. This method helped highlight implementation changes, challenges, facilitators, and lessons learned.

Results

We identified several broad themes about the strengths and challenges associated with the FSP Innovation Project. In this section, we first describe the accomplishments of the FSP Innovation Project, overall and in terms of the targeted innovation areas. We then discuss lessons learned from implementation, including implications for the overall sustainability of the interventions. We conclude with a summary of findings identified in the interviews.

Impact of the FSP Innovation Project

County leadership worked with Third Sector to identify areas to focus on for implementing interventions (see Table 1). All six participating counties committed to defining key populations and defining and tracking process and outcome metrics. In addition, counties selected a few additional interventions to implement locally based on their priorities. Five of the counties were working on step-down or graduation guidelines. Three addressed service requirements. Two counties focused on eligibility guidelines. Two counties worked on reauthorization processes. Two addressed improving their data collection processes, and one of them also worked on addressing referral guidelines. One county worked on its referral and enrollment processes for youth FSP programs.

Interviewees were asked to share their perspectives on strengths of the FSP Innovation Project and share what changes or new activities they undertook. Across participating counties, four key strengths of the FSP Innovation Project emerged. Information about these key strengths is presented below, followed by impact within the targeted areas of the project.

The Multi-County FSP Innovation Project Helped Reinforce the Program's Mission

FSP programs are designed to provide comprehensive health and social services to support individuals experiencing severe symptoms of SMI and having significant practical needs (e.g., people experiencing homelessness) across California. Some interviewees highlighted how participating in the FSP Innovation Project reminded county leadership, administrators, and providers of exactly what the FSP policies and regulations are and underscored the impor-

tance of focusing on mechanisms that best support their counties' most-vulnerable FSP recipients (e.g., strengths-based models of care). One leadership interviewee discussed the importance of achieving clarity "across the spectrum, from executives down to staffing to now know what an FSP means, what it entails, and what it should look like," as a strength of the project. **Participation reminded counties of their FSP programs' mission.** For example, one administrator remarked that FSP programs should "foster independence and [help individuals served] connect to their community" so that those in the program can ultimately utilize "the lowest level of care possible. . . . [The project was] a reminder to everybody that that's what we're doing."

The Multi-County FSP Innovation Project Facilitated Collaboration Across and Within County FSPs

Representatives from almost all counties spoke to the importance of the **knowledge sharing across and within counties** that was fostered by the FSP Innovation Project. One county administrator stated, "I think we had a lot of really good dialogue in the FSP Innovation Project, and it was great to talk to other counties and see how they were problem-solving. So, I think the information sharing" was a strength. Interviewees from two counties attributed this collaboration to the effective facilitation of the FSP Innovation Project by Third Sector. Within counties, a few interviewees specifically mentioned positive collaboration with providers. One provider shared that they "loved that the project got provider feedback" and that this feedback led to an end product for graduation guidelines. One FSP leader reported that a major accomplishment of the FSP Innovation Project was bringing together county leaders, FSP providers, and individuals served to design innovations. Another noted that such engagement increased FSP provider buy-in related to innovations.

The Multi-County Innovation Project Achieved Buy-in from Leadership, Administrators, and Providers on the Benefits of Increased Standardization and a Population-Based Approach to FSP Planning

Half of the participating counties specifically noted that a strength of the FSP Innovation Project was **increased standardization** (e.g., language, practices, and forms) related to FSP service provision. In general, interviewees reported that increased standardization would help FSP services be delivered to those with the highest level of need in a timely manner by ensuring that programs' capacities are not used up by those with less intensive service needs. One person in a leadership role shared that the project "provided a lot of clarity," and they "think that's had an impact" on developing clearer guidelines. One interviewee noted that increased standardization created an opportunity to serve larger portions of the population. They explained that, prior to standardization, it was easy to focus solely on individual-level needs rather than looking at what best serves the population overall. Creating a standard approach allows room for the diversity of different individuals who might benefit from FSP services, including those across both rural and urban localities.

"I think we had a lot of really good dialogue in the FSP Innovation Project, and it was great to talk to other counties and see how they were problem-solving. So, I think the information sharing" was a strength.

The guidelines developed were an "amazing outcome" of the FSP Innovation Project.

Third Sector Staff Were Helpful Facilitators for the Multi-County FSP Innovation Project, but Participants Felt That Project Processes Could Be More Efficient

Project participants identified several ways that **technical assistance from Third Sector was helpful** throughout the project. Some saw "value [in] . . . putting multiple subject-matter experts together and pulling on all their ideas to strategize." Others reported that they appreciated Third Sector's facilitation style. One county administrator said, "Third Sector was a pleasure to work with. They were both welcoming and noninvasive." Participants reported that Third Sector "did a good job of making the big group smaller" by identifying and connecting programs with similar goals and challenges. Others reported that Third Sector summarized and disseminated information that helped them process information shared by subject-matter experts and in discussions.

At the same time, some interviewees reported the process of developing innovations via the FSP Innovation Project could have been more efficient. Many interviewees commented on the pace and timing of the FSP Innovation Project. Some found that "repetition, a lack of clarity, [and] a lack of direction" during project meetings prevented important steps and slowed decisions about innovations. One interviewee described the process as "pretty slow moving" but noted that the project gained momentum once participants understood relevant program details. A different interviewee reported that they had hoped that the time invested in the FSP Innovation Project would have resulted in a "final product that we can use, . . . [such as] tool[s] that can support [project] work." Another interviewee suggested that inviting key decisionmakers and clarifying the roles of project participants may have improved the effectiveness of the project. That interviewee shared that it "would have been good to have one person per county who was the ultimate decider. It was difficult to have good final product [decided on by] committee."

Project Accomplishments by Targeted Innovation Activities

Table 1 provided an overview of the innovation activities targeted by one or more participating counties. In this section, we describe their accomplishments in each of these areas, in turn.

Defining Key Populations

Counties collaborated successfully to define six key populations for eligibility and outcomes tracking, using the best practices of the California Institute for Behavioral Health Solutions—a behavioral health consultancy with expertise in California systems of care—to aid their process.[13] The participating counties acknowledged that the absence of standardized definitions for their populations created difficulties in understanding who is eligible for FSP programs. Additionally, it was challenging to assess the effectiveness of programs across counties because their definitions do not always align. For instance, one county may consider living in a motel as stable housing, while another county may classify it as a form of homelessness—relevant to both key populations and outcome metrics (see the next section).

One county discussed the need to update guidelines for defining its key populations, noting that the guidelines developed were an "amazing outcome" of the FSP Innovation Project. Another county emphasized the importance of reminding its team to focus on its target population through a behavioral health lens. Although many individuals in the county have needs that the program can assist with, it is crucial to determine whether the FSP program is the appropriate program for them to participate in or whether better-suited programs exist that can also connect them to necessary resources, thus ensuring that the right participants are enrolled in the FSP programs.

One leadership interviewee noted, "We are now safeguarding this program for those who really need it." Ultimately, **the FSP Innovation Project aided in providing clarity and specificity around populations served** for the counties that prioritized this metric.

Defining and Tracking Outcome and Process Metrics

In this targeted innovation activity, the counties made efforts to improve their outcome and process metrics, with dedicated endeavors toward cross-county standardization and staff retraining. **The counties successfully identified common process metrics**, such as the number of encounters for services—for example, individual therapy, group therapy, rehabilitation services, medication management, case management, and flex funding provided to support housing. **Counties also established key outcome metrics**, including increased stable housing, reduced justice system involvement, reduced utilization of psychiatric services, and increased social connectedness.

Interviews revealed that most of the data needed to inform the cross-county metrics were already collected as part of standard FSP care and statewide requirements, so few changes to data collection and tracking processes were needed. However, the brief social connectedness measure required additional data collection—which most counties were not able to immediately implement. An interviewee also noted that the social connectedness measure "is sustainable and gives qualitative insight to case managers." Although most of the data already existed, it was not easy to pull them in a consistent manner that enabled examination of common metrics using the data. To this end, a Third Sector contractor worked with counties to develop a template that all counties could integrate into their processes, drawing on the common metrics identified through the FSP Innovation Project. Each county could upload its data and receive the same output for its outcome metrics.

Step-Down (Graduation) Guidelines

Overall, the FSP Innovation Project's **efforts to define graduation and step-down guidelines were successful**, with all five of the counties that engaged in this targeted innovation activity establishing revised guidelines. Three of the five participating counties reported successfully establishing and implementing common step-down guidelines as part of the innovation process. The other two counties shared that they developed guidelines but had yet to implement them. The impact of these guidelines appeared to vary across the counties. Leadership at one county described this process as "smoothing out the edges" around what graduation and stepping down looks like for their participants and that the multi-county work groups were helpful for developing definitions and gaining clarity around graduation.

Two of the interviewed counties identified best practices for graduation guidelines through a collaborative process between FSP program providers and county mental health departments. One county noted that the primary impact of these discussions was to increase awareness that FSP participants should not be indefinitely enrolled in FSP programs. An FSP program provider from another county described an increased effort to track progress and increase the number of graduations since being involved in those discussions. Similarly, another FSP provider reported that because of the FSP Innovation Project, the clinic spends time in staff meetings discussing participants and the frequency of contact to determine whether they could be eligible for a different program. The providers ask the question, "Does this person need us?" If not, "Do we have other, better-suited options for this client?"

Counties facilitated on-the-ground implementation of the new guidelines using such strategies as incorporating step-down criteria into provider contracts as optional guidelines, developing a training for providers and poster-sized guidelines to share with all agencies, developing and implementing a graduation binder, and offering a transition program prior to graduation. A county noted that the graduation binder was a small change that improved the step-down process and helped their participants "feel more hopeful. This binder shows them their journeys and the successes they have accomplished."

Service Requirements

Three counties worked to develop minimum requirements for services offered by FSP programs. The impact of this effort was mixed, with varying outcomes and efforts across the three participating counties. One member of county leadership reported that their county successfully established a set of mandatory FSP service requirements, which included psychotherapy. Another county representative explained that service requirements depend on local context and priorities and could include the percentage of field-based services, the availability of telehealth options, housing services, employment services, and peer supports. The third county did not discuss any innovations made to service requirements during our interviews. The low number of participating counties makes it challenging to interpret interview findings on service requirement innovation goals.

Reauthorization Process

Two counties worked to standardize the processes for reauthorizing FSP enrollment for those who do not meet step-down criteria. Again, the impact of the FSP Innovation Project was mixed for this targeted innovation activity. One county revised its reauthorization processes. This county collaborated closely with its providers and mentioned the need for good communication between leadership and providers when discussing precarious changes, such as reauthorizations, and emphasized that the goal of reauthorization is to build capacity in programs by ensuring that the right individuals get reauthorized and others are appropriately assessed for readiness to step down. The county has its FSP providers "submit info about why someone is in the program each year" to assess their reauthorization and explained that it is working with FSP programs to "help them see the impact of discharge." The other county did not report implementing changes to its reauthorization process. As above, it is challenging to interpret these findings, because only two counties targeted the reauthorization process as part of the FSP Innovation Project.

Eligibility Guidelines

Two counties worked to revise county-specific eligibility guidelines for enrollment in FSP programs. **Both counties successfully established FSP eligibility guidelines, and representatives reported that their work on FSP eligibility criteria was beneficial to their counties.** One interviewee discussed gaining "clarity" around eligibility guidelines for their programs. The individual discussed developing an improved and more clearly targeted population. The FSP Innovation Project helped streamline eligibility guideline processes. The other county discussed gaining clarity around the definitions of *homelessness* and *medical necessity*. Representatives were able to review the eligibility guidelines of other counties through the project and adjust some of their eligibility criteria. One interviewee shared that their "county developed very detailed guidelines."

Data Collection Processes

Two counties **successfully streamlined existing data collection processes or developed new ways of collecting data that can inform care decisions.** Representatives from one county shared that they developed a universal referral form in a centralized location so that participant-specific information can be assessed quickly as needed. They noted developing processes to collect data at multiple points so that participant goals can be recorded and assessed over time. An interviewee explained that "it takes a whole team to stay consistent in collecting information" and that "it helps us. It helps the client, and it helps the tracking system." Representatives from the other county described using the Level of Care Utilization System (LOCUS) form and score sheet and adding these data to their caseload tracking.

Representatives from one county explained that implementation is still in development and noted that it was too early to measure impact, and representatives from the other county said that their implementation is complete but did not mention any notable impact during the interview.

Referral Guidelines

One county aimed to create a standardized FSP referral form that captures key data. This county reported that it **successfully developed both paper and online referral forms and created revised referral processes.** The referral form included a checklist with referral criteria and the required referral processes.

Interviewees described the implementation process as ongoing and thus impact is not yet known.

Referral and Enrollment Processes

One county **successfully developed a referral and enrollment process for youth FSP programs.** First, the county reviewed referrals and noticed a lack of standardization across providers. The county "worked with providers to narrow down information needed" and implemented this feedback into its process. The county then established a revised process for reviewing the eligibility of referred youth for enrollment in FSP programs. It developed a checklist for use by DBH staff to support the screening process for program entry. The county also worked to train referring providers on the requirements for admission to youth FSP programs to reduce the number of inappropriate referrals that require screening.

Lessons Learned About the Implementation and Sustainment of Multi-County FSP Innovation Project Changes

The qualitative interviews conducted as part of this evaluation revealed several lessons related to the implementation and impact of the FSP Innovation Project.

Shared decisionmaking between FSP leaders and program staff facilitated implementation. Interviews highlighted the importance of including providers in the shared decisionmaking process. Some interviewees reported that engaging FSP providers in implementing innovations was generally well received by providers because the engagement was collaborative in nature and not punitive. Some credited Third Sector for working "so closely with providers throughout the process [that] the rollout of new policies and procedures went smoothly, with no pushback." Similarly, others reported that collaboration between FSP leaders and providers prevented implementation delays. For example, one county received feedback that the providers using a newly developed step-down tool found it to be helpful, especially because the providers helped co-design the product. Interviews revealed that it was important to communicate early and often with the providers who will be responsible for implementing new policies and guidelines. Those counties that had more provider input seemed to have an easier road to implementation.

Co-designing and implementing a countywide standardized referral form helped some counties improve their communication, participant data collection, and care coordination. One county worked collaboratively with its FSP program providers in reviewing each program's referral forms to identify common elements and reach a consensus on the most-essential items for inclusion in the final standardized referral form to be used by all FSP program providers. This co-design process highlighted the importance of communication between FSP leaders and FSP providers, as well as among FSP providers. This communication resulted in consensus about standard data elements in the referral form, despite program differences. One county reported that a paper-copy version of this standardized referral form had been implemented, although the online version of the form had not yet been incorporated into the county's EHR system. An interviewee noted, "It is so helpful to have something like this in place for care coordination." An interviewee from another county reported that the standardized form was very similar to the one that was previously used in their county, so the county did not expend resources on implementing a revised form. This example suggests that a shared decisionmaking process can facilitate implementation by easing the adoption of FSP Innovation Project innovations, increasing the spread of systems that work across counties, and reducing effort spent implementing unnecessary changes.

Some FSP providers reported insufficient dissemination of the innovations and training on how to implement them. Some counties took different approaches to disseminating innovations and training FSP staff. One county included the innovations it created for step-down criteria as a recommendation in its FSP provider contracts. The county also produced email notifications, informational posters, and provider trainings that were designed to disseminate information about project innovations. Interviews suggested that these dissemination materials were not sufficient to create changes among FSP staff. Some provider interviewees reported being unaware of FSP innovations, including step-down guidelines.

Overall, workforce recruitment and retention may be a critical factor in the successful implementation and sustainment of efforts associated with the FSP Innovation Project.

Other provider interviewees shared that counties did not follow up after the initial email announcement introducing these guidelines and resources.

Interviews revealed that FSP staff and providers require additional training on innovations developed during the FSP Innovation Project. One county's representatives discussed the need for additional funding to provide training around the new interventions and processes. A different county's representatives explained that staff were trained to ask about social connectedness, but the uptake had been inconsistent and challenging. Another county's representatives noted that "guidelines have been shared but we still need to work on developing trainings to ensure uniform implementation and uptake." Overall, both county leadership and providers discussed the need for training to understand and implement the innovations.

Some structural and contextual factors inhibited the implementation of innovations developed as part of the Multi-County FSP Innovation Project. Some interviewees reported challenges in making changes to **information technologies** to correspond with the innovations in defining and tracking FSP outcomes. For example, some counties noted that incompatibilities between state- and county-data EHR systems resulted in workflow problems and redundancies.

Workforce shortages were cited as a barrier to the implementation of the FSP Innovation Project. These shortages were reported by county administrators and FSP providers and appeared to be exacerbated during the COVID-19 pandemic. Two interviewees discussed spending months trying to fill positions in their FSP programs, which prevented them from implementing new processes or procedures related to the programs because they did not have the adequate staff to train and implement the changes. For example, one county developed a new referral and enrollment process that required county staff to review incoming participant referrals. A preexisting staffing shortage resulted in delays in the review process. As a result, this county reassigned county staff to conduct these reviews, taking these staff away from work on other important projects. Another county reported that staffing shortages were a barrier to implementing FSP service requirements because county FSPs did not have the bandwidth to meet these requirements. Other interviewees highlighted burnout as a significant workforce issue that is a barrier to sustaining innovations from the FSP Innovation Project, with some being reluctant to ask more of strained staff. Overall, **workforce recruitment and retention** may be a critical factor in the successful implementation and sustainment of efforts associated with the FSP Innovation Project.

Participants in the FSP Innovation Project also suggested that the sustainment of project efforts would be influenced by larger policy and program changes in California. Interviews revealed that impending statewide changes to mental health care financing and health department recordkeeping preceded or coincided with intended changes proposed by the FSP Innovation Project. In multiple interviews, respondents reported concerns about dealing with the possible impact of statewide payment reform at the same time that they were implementing FSP innovations. Program administrators and providers also reported that changes in their countywide EHR platform may also create strains that disrupt the sustainment of efforts associated with the FSP Innovation Project. Staff reported feeling that they

had lower capacity to implement changes developed by the FSP Innovation Project because they focused resources on preparing for these other wide-scale changes. One county leader pointed out that "implementation of something like this has to be timed really well" to prevent contextual factors from disrupting progress.

Early Lessons Learned About the Impact of Innovations

Innovations developed as part of the Multi-County FSP Innovation Project increased adherence with guidelines on the enrollment, retention, and graduation of individuals served. A major focus of the FSP Innovation Project was the standardization of criteria used to determine which individuals served were eligible for FSP services. In general, interviews with county leaders and FSP providers indicated that the innovations designed as part of the FSP Innovation Project have resulted in changes to the enrollment, retention, and graduation practices used by FSPs. Broadly, the interviews suggested that FSP services are more consistently reserved for people who have the highest severity of mental health symptoms and co-occurring vulnerabilities related to housing instability, frequent hospitalization, and interactions with the criminal justice system. FSP providers shared that there is a high demand for services for people who do not meet this overall criterion but that the innovation process resulted in higher levels of adherence to enrollment, retention, and graduation guidelines. One interviewee noted that some individuals served "want housing but don't want to engage in any form of treatment. We have to remind the [individuals served] and referring parties that we are not a housing program; it is only one component of our program." Several county leaders and providers reported that the FSP Innovation Project resulted in collaborative audits of the census of individuals served to ensure that they met criteria for FSP services. Stated differently, **the FSP Innovation Project resulted in changes to ensure that the high-intensity services provided by FSP programs are reserved for the most-vulnerable individuals served.**

These innovations also created unintended service gaps. Refining enrollment criteria to ensure that FSP programs are provided only to those with severe symptoms resulted in an unintended gap in services for those with moderately severe symptoms. For example, one county reported that youth ages 0–5 with moderately severe symptoms had previously been served by a county FSP program. After changes to enrollment guidelines, these youth were no longer eligible for FSP and instead were placed on waiting lists for other programs. This county reported that families of children with moderately severe symptoms now struggle to find providers trained in evidence-based practices to care for these children. More broadly, several interviewees reported that these changes to enrollment created problems in connecting individuals with care in a timely manner.

Interviews revealed a similar issue associated with innovations in graduation criteria. One interviewee stated that the "lack of [an] intermediate step

The interviews suggested that FSP services are more consistently reserved for people who have the highest severity of mental health symptoms and co-occurring vulnerabilities related to housing instability, frequent hospitalization, and interactions with the criminal justice system.

Improvements in adherence to FSP enrollment, reauthorization, and graduation criteria created a dilemma for programs that lacked alternative practical supports for those who did not meet FSP enrollment criteria and for those who were ready for graduation from FSP programs.

between [the FSP] level . . . [and lower levels of care] . . . makes implementation of graduation difficult. It feels like a big leap" for individuals who received intensive support from FSPs to transfer to typical outpatient treatment. Other interviewees reported that they had difficulty finding lower-intensity services that had availability to enroll those individuals who graduated from FSPs. Some FSP providers reported that individuals served were hesitant to lose the long-standing, trusting relationships that they developed with FSP providers and to establish relationships with new providers upon meeting graduation criteria. Some providers reported that they took steps to fill the gap created by the FSP Innovation Project. For example, some reported that they supported individuals served through the transition to new providers and remained in contact with them until they were engaged in appropriate lower-level care. FSP providers reported that they took these steps to ensure that individuals who graduate from FSPs do not experience a relapse in the severity of their symptoms as a result of transitioning to a lower level of care.

FSP administrators and providers reported that programs had historically offered services to those who did not meet criteria for FSP programs to more easily provide participants with housing, transportation, and financial support. Improvements in adherence to FSP enrollment, reauthorization, and graduation criteria created a dilemma for programs that lacked alternative practical supports for those who did not meet FSP enrollment criteria and for those who were ready for graduation from FSP programs. For example, FSP providers pointed out that when individuals served by FSP programs experience improvements in their mental health and functioning, they may still need housing support. One service provider said, "We can refer [individuals served] back to DMH [the Department of Mental Health—i.e., a DBH], but they can't afford to spend $1,400 to $1,500 on an apartment, because that is all of their income." Many reported that these individuals served could lose vital housing and transportation supports if they are referred to a lower-intensity level of care.

Representatives from some counties reported that they faced policy and administrative barriers to addressing the practical needs of individuals who did not qualify for or who graduated from FSP programs. FSP administrators reported that, with the exception of FSP funding, policies create separate pools of funding for mental health services and housing services. Interviewees reported that one county had housing funds for program participants but faced administrative barriers in using these funds. One leader reported that the "biggest change is around our . . . use of basic-needs funding. There was a lot of underutilization of those funds. . . . We are waiting on fine tuning some stuff with our fiscal department to be able to use" this funding more efficiently. **Policy changes may be needed to increase access to practical and financial supports for people who do not meet enrollment criteria for, or who graduate from, FSP programs.**

FSP administrators and providers advocated further development of a full continuum of care to mitigate service gaps caused by improved adherence to FSP criteria. FSP programs that had good access to a full continuum of care that spanned low- to high-acuity services reported fewer gaps in services for people who did not qualify for FSP services or who were ready for graduation from an FSP program. FSP providers described a need for a care continuum in which individuals served could work with a single provider while receiving more or less intensive care based on their needs. Individuals served would benefit because they would not be required to switch providers when they moved across different levels of care. Developing a full continuum of care may also address concerns about supportive housing and transportation needs for individuals served (see the previous section). Additionally, having a full a continuum of care within a given provider organization would facilitate more rapidly increasing the intensity of services for individuals served when their symptoms or circumstances changed. For example, when discussing criteria that disallow the reauthorization of services to people who have not attended an FSP appointment, one interviewee said, "I would always fear that, at the 60-day mark, we discharge [an individual served by an FSP program who has engaged in care], and a week later they are hospitalized and have to be reenrolled" and experience a delay in receiving services. Organizations that offered FSP services as part of a full continuum of care could avoid delays in transitioning individuals to both higher- and lower-acuity services.

Discussion

Interviews with county staff and FSP providers highlighted important interventions that were implemented across the six participating counties. **Counties successfully developed standardized definitions for key populations:** individuals experiencing homelessness, those with justice system involvement, and those at risk of experiencing homelessness and justice system involvement. This standardization will help create clarity around eligibility for programs and the effectiveness of FSP programs. **All counties successfully identified common process and outcome metrics,** which can be used to measure the success of their programs and facilitate cross-county conversations about FSP processes and outcomes. **Several counties succeeded in creating step-down and graduation guidelines to clarify when program participants are ready to move to a lower level of care and free up FSP capacity** for those who need the services. With respect to innovations pursued by a small number of counties, two counties successfully implemented improved data collection processes and two others reported changes in referral guidelines or referral and enrollment processes. Counties varied in the extent to which they implemented standardized service requirements and reauthorization processes.

After the initial development of innovations, there were variations in the sustained success of implementation efforts, with some counties reporting little on-the-ground implementation of the processes designed in the innovation projects and others sharing success stories with implementation and confidence in sustainability over time. **Involving providers in the changes seemed to facilitate the successful implementation of innovations.**

Findings suggest that **increased provider training may facilitate on-the-ground implementation of the innovations.** It will also be important for future innovation projects to **address step-down options** for those who do not require FSP-level care, in light of concerns about service gaps as an unintended consequence of increased attention to enrollment and graduation criteria. These gaps in care cannot be fully addressed by the Multi-County FSP Innovation Project, but they contributed to concerns for the ongoing sustainability of the successfully made changes.

Quantitative Evaluation: Findings from Patient Data

The quantitative component of the evaluation analyzed EHR and program data to answer evaluation questions about (1) the impact of FSP programs on participant outcomes and (2) whether this impact changed over time as a function of Multi-County FSP Innovation Project participation. We conducted a pre-post comparison of key outcomes for 2,555

FSP program participants, looking at changes within individuals served over time.

Methods

Study Data

We evaluated the effectiveness of FSP programs on improving participant outcomes by comparing data that covered the year prior to a participant's enrollment in an FSP program with data covering the first 12 months after enrollment to assess whether outcomes improved after enrollment. Our analyses relied on two primary data sources: the MHSA FSP Data Collection and Reporting System (DCR) and EHRs from the counties' DBHs. The DCR system includes the Partnership Assessment Form (PAF), which is completed when a participant enrolls in an FSP program; the Quarterly Assessment Form (3M), completed every three months of participation; and the Key Event Tracker (KET) data that contain records for each change in a participant's housing, employment, or education. The EHR data identify each time a service is provided to an FSP participant and includes the type of service and the date on which it was provided.

We also evaluated the potential impact of a county's participation in the FSP Innovation Project by comparing changes in FSP participant outcomes prior to the start of the project with outcomes after the project ended.

The FSP Innovation Project's design and implementation phase with the first cohort of counties took place from October 2020 through October 2021, and we requested DCR and EHR data for all FSP participants who enrolled at any time from July 1, 2019, through October 31, 2023.

Outcome Metrics

The outcome metrics selected for the FSP Innovation Project were associated with the success of FSP programs and were carefully aligned with the primary objectives of the DBHs and FSP programs. The metrics were selected by participating counties through a collaborative process guided by Third Sector (Table 2). The outcomes were to increase stable housing, reduce the utilization of inpatient psychiatric services, reduce justice system involvement, and increase social connection.

We assessed the impact of FSP participation on these outcomes by comparing their values in the year prior to enrollment to the first year of participation. All outcome metrics with the exception of social connection were tracked in the DCR data. Data for the 12 months prior to enrollment were captured on the PAF through a series of items that covered housing status, inpatient psychiatric admissions, and arrests.

TABLE 2
Outcome Metrics Selected by the FSP Innovation Project

Outcome Metric	Definition
Days of stable housing	The number of days during the 12 months pre- and postenrollment that a participant experienced stable housing in a home in which they hold the lease or share in the rent or mortgage, with adult family members, or in a single-room occupancy (must hold lease)
Number of mental health inpatient admissions	The number of times during the 12 months pre- and postenrollment that a participant was admitted to a psychiatric hospital or general hospital to receive psychiatric care
Number of mental health inpatient days for those with an admission	The number of days during the 12 months pre- and postenrollment that a participant with an admission experienced in psychiatric hospitals or general hospitals to receive psychiatric care
Ever arrested (yes or no)	Was the participant arrested during the 12 months pre- and postenrollment?
Number of arrests for those with at least one	How many times was the participant arrested during the 12 months pre- and postenrollment?
Social connectedness (Likert scale, never to always)	How often did the participant get the social and emotional support they needed during the 12 months pre- and postenrollment?

NOTE: DCR, PAF, and KET data are used to compute all but social connectedness. Counties planned to add social connectedness to the 3M assessment, but we did not receive any data that included this measure.

These items had the following structure: "How many times in the past 12 months did you live with a family member?" and "How many days during the past 12 months did you live with a family member?"

The 12 months prior to a participant's enrollment was the only period covered by items in the PAF, so we created outcome metrics before and after enrollment that covered 12 months. Data for the first 12 months of participation after enrollment were captured in the KET. Even though data included enrollment through October 2023, we limited our study to participants who enrolled July 2019 through October 2022 to observe a complete 12 months of FSP participation. For participants who enrolled through October 2022, we used KET data through October 2023 to compute the outcomes following enrollment.

Counties agreed to add a measure of social connection as part of the FSP Innovation Project, but adding a new measure was challenging, and the counties were unable to implement this during the data collection period we examined. Therefore, we were unable to assess the impact of FSPs on social connection.

Service Utilization

FSP participants commonly receive case management, rehabilitation, medication management, and psychotherapy, among other services. We used EHR data to count the number of each type of service FSP participants utilized during the first 12 months of their enrollment and then used these counts to evaluate whether there is an association between utilization of these services and outcomes for FSP participants. FSP participants received services after enrollment, so we did not have EHR service data for the time prior to enrollment. We were unable to discern a causal relationship between receiving services and participant outcomes because we could only observe both, without differentiation, during the same period.

Although our outcome metrics were consistently coded in the DCR data, there was variation in how counties recorded services. The DCR assessments and KET data were specified by the state. Counties were able to add a few measures of their own (such as social connection), but the existing measures were coded the same. There was no such consistency in the EHR data because of differences in how counties coded their services and in EHR providers. We reviewed service codes in the EHR data we received and classified them into the following categories:

- case management
- individual therapy
- group therapy
- medication management
- rehabilitation services.

Housing services were not separately identified from case management in most counties' EHRs. Consequently, we used case management services rather than housing services as a predictor of housing outcomes.

Statistical Models

To estimate the association between FSP participation and changes in outcomes, we compared each of the outcomes in Table 2 for the 12 months prior to FSP enrollment with the first 12 months of FSP participation. This model answered the question, "Did FSP participants demonstrate improvement before versus after participation?" In other words, did they get better over time?

We estimated models with a pre-post structure:

$$Y_{it} = m_0 + m_1 post_{it} + m_2 y2020_i + m_3 y2021_i + m_4 y2022_i + \varepsilon_{it},$$

where Y_{it} is the outcome for participant i in time period t (pre-post), $post_{it}$ is an indicator for the first 12 months after enrollment in an FSP program, and $y2020_i$–$y2022_i$ are indicators for the year in which participant i enrolled. The coefficient estimate, m_1, is our estimate of the association between participation in an FSP program and each outcome. We included calendar-year indicators to control for state-level external effects, such as state policies or societal changes, that could also influence the outcomes. For instance, a statewide initiative about housing could inadvertently affect the housing stability outcomes for FSP participants, and the COVID-19 pandemic could affect service utilization. By controlling for these external factors, the model seeks to isolate the effect of FSP participation from other statewide changes. We did not include county indicators in

Participants experienced an average increase of 128 days of stable housing in the first year of FSP participation. The total number of psychiatric admissions decreased on average by 2.5 admissions.

keep the focus on the general effect of FSP participation rather than on comparing performance across different counties. This approach aligns with the report's goal of evaluating the statewide effectiveness of FSP programs, assuming that a program's influence on outcomes is consistent across California. We used maximum likelihood to estimate the association and cluster standard errors by county and participant identification number to account for the hierarchical structure of the data.

To estimate the association between FSP service utilization and participant outcomes, we focused on the first 12 months of FSP participation and regressed each outcome on the number of times a participant received each type of service:

$$Y_i = m_0 + m_1 casemanagement_i + m_2 individualtherapy_i + m_3 grouptherapy_i + m_4 rehabservices_i + m_5 medicationmanagement_i + m_6 y2020_i + m_7 y2021_i + m_8 y2022_i + \varepsilon_i$$

where Y_i is the outcome for participant i, each of the five service types represent the count of services received by participant i during the first 12 months of FSP participation, and $y2020_i$–$y2022_i$ are indicators for the year in which participant i enrolled. The coefficient estimates, m_1–m_5, are the estimates for how the intensity and type of services provided by FSPs are associated with participant outcomes. We used maximum likelihood to estimate the association and cluster standard errors by county to account for the hierarchical structure of the data.

To estimate the association between a county's participation in the FSP Innovation Project starting October 2021 and potential changes in FSP participant outcomes, we compared each FSP participant's outcomes before and after enrollment in a program and added an indicator that identifies when that enrollment occurs in months after the start of the FSP Innovation Project. This model answers the question, "Is participation in the FSP Innovation Project associated with greater improvement in outcomes over time?"

We estimated models with a pre-post structure and included a term that captures the interaction between the first 12 months of FSP participation (*post* from our equation above) and the year of enrollment after the end of FSP Innovation Project (November 2021 through October 2022):

$$Y_{it} = m_0 + m_1 post_{it} + m_2 post_{it} X\, innovation_i + m_3 y2020_i + m_4 y2021_i + ym_5 y2022_i + \varepsilon_{it}$$

where Y_{it} is the outcome for participant i in time period t (pre-post enrollment in an FSP program). As in the previous equation, $post_{it}$ is an indicator for the first 12 months after enrollment in an FSP program. The interaction term, $post_{it} X\, innovation_i$, is the interaction between the first 12 months after enrollment in an FSP program for a participant and the end of county participation in the FSP Innovation Project. This term captures moderation of the FSP program effect—whether the effect increases or decreases as a function of FSP Innovation Project participation. The terms $y2020_i$–$y2022_i$ are indicators for the year in which participant i enrolled. The coefficient estimate, m_2, is our estimate of the incremental association between participation in an FSP program and each outcome after the end of the FSP Innovation Project.

The forms of the models depend on the distributions of the outcomes. The number of days of stable housing and the length of stay for psychiatric admissions are distributed normally and use linear models to estimate these associations. The number of psychiatric admissions is a count of relatively rare events and has an excess of zeros, so we used zero-inflated negative binomial models to estimate these associations.[14] Whether a participant is arrested is a yes-no outcome. We used a common approach in modeling outcomes of this form and estimated this association with a logit model. We reported the average marginal effect, or the average effect in the population of FSP participants of a change in the variable of interest on the outcome.

KETs are completed only when a key event occurs, such as a change in housing status. The absence of a KET form is meant to indicate that there was no change to record, and we analyzed the data assuming that this was accurate (i.e., no KET indicated no event). However, a limitation to this data collection method is that we could not definitively distinguish between whether the individual served did not experience any events or whether they experienced an event but a form was not completed. However, we think that if there are missing data, the evaluation findings are unlikely to be affected in a systematic manner.

Results

Data Description

We received DCR data for 2,555 FSP participants enrolled from July 2019 through October 2022, across six participating counties. We needed each participant's PAF record to identify outcomes prior to enrollment in an FSP program, and we received PAF records for 2,143 (84 percent) of the participants, so our analyses are based on this subgroup of participants. To identify outcomes during FSP participation, we needed both the DCR KET data on key events, such as changes in housing status, and the EHR data. Among the participants we analyzed, 69 percent had at least one event record, and 88 percent had at least one EHR record.

Association Between Changes in Outcomes and Participation in FSPs

FSP participants experienced significant improvement on average for all of the outcomes we evaluated, except length of stay in a psychiatric inpatient setting (Table 3). The changes reported in the last column on the table represent the average change after controlling for the year of enrollment in an FSP. Participants experienced an average increase of 128 days of stable housing in the first year of FSP participation (95 percent confidence interval [CI]: 120 to 136 days), compared with the 12 months prior to enrollment. Both the likelihood of being arrested (−26 percent; 95 percent CI: −23 percent to −29 percent) and the number of arrests (−0.5, 95 percent CI: −0.2 to −0.8) among those with any arrest decreased on average for FSP participants. The total number of psychiatric admissions decreased on average by 2.5

TABLE 3

Change in Participant Outcomes from One Year Prior to Enrollment in an FSP Program and One Year Postenrollment

Outcome Metric	Average During Year Preenrollment	Average During Year Postenrollment	Change in Average Value After Controlling for Year of Enrollment[a]
Number of days of stable housing	120.6	248.8	128.2***
Ever arrested (%)	31.0	5.1	−26.4***
Number of arrests for those with at least one	1.9	1.4	−0.5**
Number of psychiatric inpatient stays	1.6	0.1	−2.5***
Length of stay for those with an admission (days)	56.6	41.0	−15.3

NOTE: * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

[a] Estimated difference in outcomes (postenrollment − preenrollment) for FSP participants based on a regression model controlling for year of enrollment. The values reported in this table are the marginal effects from the model estimates based on the maximum likelihood, with standard errors clustered at the county and participant levels.

admissions (95 percent CI: −1.7 to −3.3), but the average annual length of stay for those who had at least one admission did not change significantly.

Service Utilization

Table 4 summarizes utilization by FSP participants of key services during the first 12 months following their enrollment. Case management was the most common service, utilized by 94 percent of FSP participants, with an average of 22 services or roughly once every two weeks. Rehabilitation services were also utilized an average of 22 times during the year by 84 percent of participants. Most participants (82 percent) utilized medication management services, and fewer than half (41 percent) utilized individual or group therapy. It is possible that participants received case management as part of rehabilitation or medication management services, and it also possible that participants received additional services during a visit that were coded as case management.

Association Between Service Utilization and Changes in Outcomes

Service utilization is associated with each of the outcomes we evaluated (Table 5). Each use of therapy by an FSP participant is associated with an average decrease of 0.009 arrests (95 percent CI: −0.0001 to −0.016), an average decrease of 0.01 psychiatric inpatient admissions (95 percent CI: −0.0004 to −0.01), and an average decrease of one day in the length of stay for those who were admitted (95 percent CI: −0.7 to −1.3). Medication management utilization is

TABLE 4

Summary of Key Service Utilization in the 12 Months Following Participant Enrollment in an FSP Program

Service	Enrollees with Any (%)	Average Number of Services	Minimum	Median	Maximum
Therapy	40.6	4.9	0	0	185
Medication management	82.4	9.1	0	5	114
Rehabilitation services	84.4	22.2	0	13	281
Case management	93.6	21.9	0	13	265
Any of above types of services	100.0	59.7	1	44	416

TABLE 5

Estimated Difference in Participant Outcomes Associated with Amount of Service Utilization

Services	Days of Stable Housing	Any Arrests? (%)	Number of Arrests Among Those with Any	Number of Psychiatric Inpatient Admissions	Length of Stay (Days) for Those with an Admission
Therapy	−0.1	−0.2	−0.009*	−0.01**	−1.0**
Medication management	1.4***	−0.2***	−0.02*	−0.001*	0.4
Rehabilitation services	0.8*	−0.1***	0.02***	−0.0	−0.3
Case management	−0.6*	0.1***	−0.001	0.001*	0.3*

NOTE: The estimated change is based on regression model controlling for year of enrollment. The values reported in this table are the marginal effects from the model estimates based on maximum likelihood with standard errors clustered at the county level. The statistically significant values are in shaded cells.

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

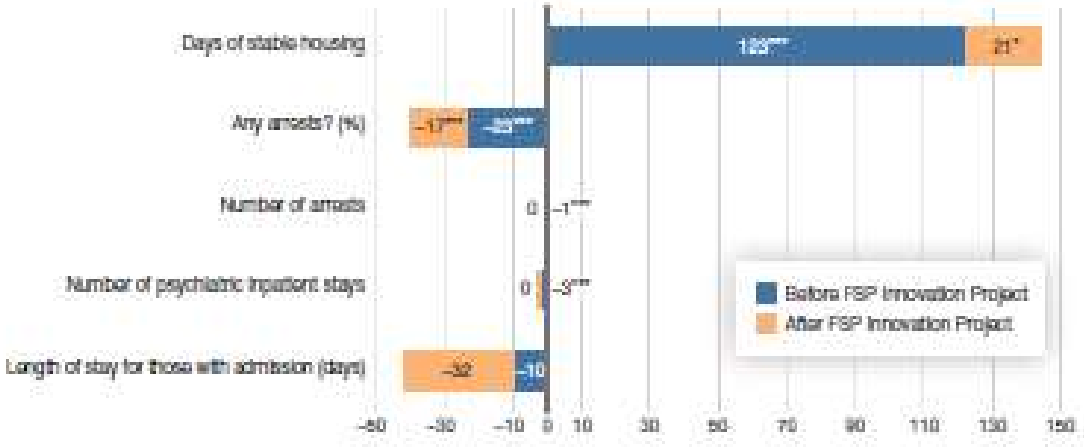
associated with increased days of stable housing (1.4 days, 95 percent CI: 1.0 to 1.8), decreased likelihood of arrest (−0.2 percent, 95 percent CI: −0.1 percent to −0.3 percent) and the number of arrests (−0.02, 95 percent CI: −0.001 to −0.04), and decreased psychiatric admissions (−0.001, 95 percent CI: −0.00004 to −0.002). Rehabilitation service utilization is associated with increased stable housing (0.8 days, 95 percent CI: 0.1 to 1.5), decreased likelihood of arrest (−0.1 percent, 95 percent CI: −0.04 percent to −0.3 percent), and *increased* number of arrests among those with at least one (0.02, 95 percent CI: 0.01 to 0.04).

Case management utilization is associated with a *decrease* in the number of days of stable housing (−0.6 days, 95 percent CI: −0.01 to −1.1) and *increased* likelihood of arrest (0.1 percent, 95 percent CI: 0.07 percent to 0.12 percent). These counterintuitive associations highlight the challenges in interpreting these results. It is possible that increased case management causes declines in some outcomes, but it is also possible (and more likely) that more-complex FSP participants with worse outcomes on average utilize more case management. We were unable to distinguish among the possible causal relationships and can only estimate an association.

Association Between County Participation in the FSP Innovation Project and FSP Program Outcomes

We examined outcomes for FSP participants who enrolled prior to the FSP Innovation Project with those who enrolled from November 2021 through October 2022, examining their data through October 2023. **FSP participants who enrolled after the start of the FSP Innovation Project experienced greater improvement in two of the outcomes we evaluated than participants who enrolled prior to the project** (Figure 2). The total length of the two-color bars in Figure 2 represents the estimated change in outcomes for those who enrolled after the FSP Innovation Project began. The blue section of the bar represents the estimated change for enrollees who enrolled prior to the FSP Innovation Project, and the orange section represents the difference in the change for enrollees who enrolled after it began. After counties began participating in the FSP Innovation Project, the days of stable housing increased an additional 21 days (95 percent CI: 2.7 to 39.1) for their FSP participants. The likelihood of arrest decreased by an additional 17 percentage points (95 percent CI: −7 percent to −26 percent). There were significant decreases in

FIGURE 2
Estimated Change in Participant Outcomes Associated with a County's Participation in the FSP Innovation Project



NOTE: The estimated change is based on a regression model controlling for year of enrollment. The values reported in this figure are the marginal effects from the model estimates based on the maximum likelihood, with standard errors clustered at the county and participant levels.
* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

After counties joined the FSP Innovation Project, the improvement in outcomes increased for their FSP participants.

the number of arrests and the number of psychiatric inpatient admissions prior to the FSP Innovation Project, but there was no significant change in this pattern after counties began participating. The additional change in psychiatric inpatient length of stay after participating is not significant.

Discussion

Outcomes for FSP participants improved during the first 12 months of participation relative to the 12 months prior to participation: **Participants experienced increased stable housing, decreased justice system involvement, and reduced psychiatric inpatient admissions.** The amount of FSP services that participants utilize is associated with changes in outcomes, but we were unable to determine whether associations are causal because our data lack a control group. In most cases, utilizing more services yielded improvements in outcomes, but utilization of case management is associated with fewer days of stable housing and an increase in the likelihood of arrests. This may be because more-complex cases that would otherwise have much worse outcomes require more case management. Nonetheless, FSP participants experienced improved outcomes on average, and the provision of most services is associated with improvement.

We found that **after counties joined the FSP Innovation Project, the improvement in outcomes increased for their FSP participants.** This finding suggests that the FSP innovations might have led to changes in the quality of care that the individuals served received or to changes in the appropriateness of the population that FSP programs serve. The qualitative data indicated that counties' identification of common metrics might have led to more-consistent use of measurement-based care, which could improve quality of care and, in turn, outcomes. At the same time, several counties succeeded in establishing guidelines for readiness to graduate from FSP programs and move to a lower level of care; this innovation might have increased capacity for individuals at the higher level of need that FSP programs are intended to serve. These higher-need individuals may be more likely to experience significant change in response to FSP participation.

Conclusion

Overall, there is evidence that the Multi-County FSP Innovation Project led to improvements in processes and outcomes among the first cohort of six participating counties. Counties worked with each other and Third Sector to successfully implement standardized definitions, measures and metrics, guidelines, and processes necessary to improve program implementation. However, there was considerable variation in the extent to which innovations were implemented on the ground and sustained after the initial innovation development and implementation period was over. Nonetheless, **we found evidence that FSP participants experienced improved outcomes in key areas, including stable housing, justice system involvement, and psychiatric hospitalizations, and that these improvements increased after counties participated in the FSP Innovation Project.** We cannot definitively attribute these improvements in outcomes to the project, but our findings may suggest that there was improved quality of care or improved targeting of FSP programs to those most in need of these high-intensity services.

Given the initial successes of the FSP Innovation Project and the lessons learned about its implementation and impacts, it may be helpful to expand the innovations to additional counties across the state—with attention to such issues as need for provider training in the innovations and step-down care options.

Notes

[1] Substance Abuse and Mental Health Services Administration, "Mental Health and Substance Use Disorders."

[2] Substance Abuse and Mental Health Services Administration, "Mental Health and Substance Use Disorders."

[3] California Health Care Foundation, *Mental Health Care in California*.

[4] Mental Health Services Oversight and Accountability Commission, *Report to the Legislature on Full Service Partnerships*.

[5] Title IV-E Prevention Services Clearinghouse, "Assertive Community Treatment."

[6] California Department of Health Care Services, "Mental Health Services Act."

[7] California Department of Health Care Services, "MHSA Components."

[8] Mental Health Services Oversight and Accountability Commission, *Report to the Legislature on Full Service Partnerships*.

[9] Third Sector, *California Multi-County Full Service Partnership Innovation Project*.

[10] Mental Health Services Oversight and Accountability Commission, *Report to the Legislature on Full Service Partnerships*.

[11] RAND Corporation, "Publications."

[12] Vindrola-Padros and Johnson, "Rapid Techniques in Qualitative Research."

[13] California Institute for Behavioral Health Solutions, homepage.

[14] Cameron and Trivedi, *Microeconometrics*.

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About This Report

This report describes the evaluation of the California Multi-County Full Service Partnership Innovation Project. Mental Health Service Act (MHSA) innovation projects seek to promote innovations that improve mental health outcomes for individuals and communities.

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CalMHSA is an organization of county governments working to improve mental health outcomes for individuals, families, and communities. Prevention and early intervention programs implemented by CalMHSA are funded by counties through the voter-approved MHSA (Prop. 63). Prop. 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California's diverse communities.

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Appendix F: FSP Services and Outcomes Ventura County

Service Utilization and Changes in Outcomes for FSP Participants in Ventura County

Introduction

The California Mental Health Services Authority (CalMHSA) contracted with RAND to conduct an independent, objective evaluation of the Multi-County Full Service Partnership (FSP) Innovation Project. The RAND team's evaluation examined the period directly following innovation implementation at the end of 2021 through 2023. We conducted a mixed-methods evaluation for all participating counties that employed both qualitative and quantitative components. These methods are documented summarized in our report.[1]

In this brief, we summarize the quantitative component of that evaluation for Ventura County. RAND analyzed electronic health records (EHRs) and program data to examine service utilization by FSP participants as well as the potential impact of FSP programs on participant outcomes.

Service Utilization

Participants in FSPs receive a number of services, including case management, rehabilitation, medication management, and psychotherapy, among others. We used EHR data to count the number of each type of service that participants received during the first 12 months after enrolling in an FSP. Table 1 summarizes this utilization.[2] All FSP participants received case management services. FSP participants received an average of 26 case management services during that year or roughly once every two weeks. Most participants utilized medication management services (92 percent), and fewer than half utilized rehabilitation services (44 percent) or individual or group therapy (31 percent). Participants might have received case management as part of rehabilitation or medication management services, and it also possible that they received additional services during a visit that was coded as case management.

Table 1. Summary of Key Service Utilization in the 12 Months Following Participant Enrollment in an FSP Program

	Enrollees with Any (%)	Average Number of Services	Minimum	Median	Maximum
Therapy	30.5	3.3	0	0	55
Medication management	91.5	14.3	0	10	114
Rehabilitation services	43.9	11.6	0	0	172
Case management	100	25.7	1	25	87
Any of above types of services	100.0	55.2	1	48	242

[1] Eberhart, Nicole K., J. Scott Ashwood, Wendy Hawkins, Alison Athey, Stephanie Williamson, Alejandro Ros Contreras, Ryan K. McBain, Stacey Yi, and Pitha Gandhi. *Evaluation of the California Multi-County Full Service Partnership Innovation Project*. RAND. 2024. We copied some of the language from that report in this brief summary. The first two sentences are copied directly from the report.Some of the wording in the sections below is similar to the language in the report.

[2] This table is similar to Table 4 in the report.

Association Between Changes in Outcomes and Participation in FSPs

We assessed the impact of FSP participation on outcomes by comparing their values in the year prior to enrollment to the first year of participation. We used items in the Partnership Assessment Form (PAF) to calculate outcome measures for the 12 months prior to enrollment and items in the Key Event Tracker (KET) for the first 12 months of participation after enrollment.

FSP participants experienced a significant improvement on average for all of the outcomes we evaluated, except for arrests (Table 2). The changes reported in the last column represent the average change after controlling for the year of enrollment in an FSP.[3] Participants experienced an average increase of 106 days of stable housing in the first year of FSP participation (95 percent confidence interval [CI]: 78 to 134 days) compared with the 12 months prior to enrollment. None of the FSP enrollees reported any arrests in the 12 months prior to enrollment, and 4 percent reported an arrest in the 12 months following enrollment with an average of 1 arrest. The likelihood of being admitted for psychiatric inpatient care (–25 percent; 95 percent CI: –17 to –33 percent) decreased, and the number of admissions (-2 admissions, 95 percent CI:-1 to -4 admissions) decreased among those with any decreased as well. The length of stay (58 days; 95 percent CI: 9 to 106 days) increased among those with any admissions.

Table 2. Change in Participant Outcomes from One Year Prior to Enrollment in an FSP Program and One Year Post-enrollment

Outcome Measure	Average During Year Pre-enrollment	Average During Year Post-enrollment	Change in Average Value After Controlling for Year of Enrollment[a]
Number of days of stable housing	118.5	224.6	106.0***
Ever arrested (%)	0	4.2	NA
Number of arrests for those with at least one	NA	1.1	NA
Ever admitted for psychiatric inpatient (%)[b]	27.0	4.2	-25.0***
Number of psychiatric inpatient stays for those with at least one	2.7	1.0	-2.4**
Length of stay for those with an admission (days)	38.8	88.8	57.9*

NOTE: * $p < 0.05$, ** $p < 0.01$, and *** $p < 0.001$. NA = Not applicable.
[a] Estimated difference in outcomes (post-enrollment – pre-enrollment) for FSP participants based on a regression model controlling for year of enrollment. The values reported in this table are the marginal effects from the model estimates based on the maximum likelihood, with standard errors clustered at the county and participant levels. We did not estimate models for outcomes with 0 for all participants pre-enrollment.
[b] The summary of psychiatric admissions here is different from Table 3 of the report. The smaller sample size at the county level required a different analytic approach.

[3] Copied from the report. This table is similar to Table 3 in the report.

Appendix G: 2024 EHR INN Report

Ventura County

Semi-Statewide Enterprise Health Record

Multi-County Collaborative INN Project

Annual Innovative Project Report

Reporting Period: July 1, 2023 – June 30, 2024

Project Period: FY 2022-23 through FY 2026-27

VENTURA COUNTY BEHAVIORAL HEALTH

In partnership with CalMHSA

California Mental Health Services Authority

Project Overview and Local Need

1. Please describe this Innovation project and its purpose.

This is a multi-county, scalable INN project that stems from a larger Semi-Statewide Enterprise Health Record (EHR) project CalMHSA is concurrently leading (the EHR Project). In fiscal year (FY) 2023-24, CalMHSA partnered with 23 California counties – collectively responsible for 27% of the state's Medi-Cal members – on the Semi-Statewide Enterprise Health Record project. In FY 2024-25, to date CalMHSA is partnering with 25 counties, collectively responsible for 35% of the state's Medi-Cal members.

This project is unique in that it engages counties to collaboratively design a lean and modern EHR to meet the needs of counties and the communities they serve.

The key principles of the EHR project include:

Enterprise Solution: Acquisition of an EHR that supports the entirety of the complex business needs (the entire "enterprise") of county behavioral health plans. This approach also facilitates data sharing between counties for patient treatment and payment purposes as patients move from one county to another.

Collective Learning and Scalable Solutions: Moving from solutions developed within individual counties to a semi-statewide cohort allows counties to achieve alignment, pool resources and bring forward scaled solutions to current problems, thus reducing waste, mitigating risk and improving quality.

Leveraging CalAIM: CalAIM implementation represents a transformative moment when primary components within the EHR are being re-designed (e.g., clinical documentation and Medi-Cal claiming), while data exchange and interoperability with physical health care — toward improving care coordination and client outcomes — are both required and supported by the State.

Lean and Human-Centered: Engaging with experts in human-centered design to reimagine the clinical workflow in a way that reduces "clicks" (the documentation burden), increases client safety and natively collects outcomes.

Interoperable: Typically, county behavioral health has, in response to state regulations, developed documentation that is out of alignment with data exchange standards. We are reimagining the clinical workflow, allowing critical information about the people we serve to be formatted in a way that will be interoperable (standardized and ready to participate in key initiatives like health information exchanges).

2. Please describe how this project makes a change to an existing practice in the field of mental health, including but not limited to application to a different population.

This project will meet the general requirements by making a change to an existing practice in the field of mental health — specifically, the practice of documenting care in an EHR that meets the needs of the county's workforce and the clients they serve. This innovative project aims to transform the standard use of an electronic health record by standing up a semi-statewide behavioral health electronic health record in collaboration with a cohort of counties. This new EHR is responsive to identified provider needs and supports the spread of best practices among the participating counties. Optimizing the EHR to meet daily workflow needs of treating providers can enhance working conditions, increase efficiencies, and reduce burnout, ultimately improving the conditions under which direct client care is

provided. With the input of provider stakeholders and best practice experts in the field of human-centered design, the new EHR is being collaboratively and intentionally designed to improve the method and ease of documenting in the EHR as well as gathering and appropriately sharing pertinent clinical information from the EHR, which will promote less time spent on "treating the chart" and more time spent on "treating individuals" in need of care.

3. Please describe how this project impacts your County's local need(s).

From FY 2022-23 report:

Ventura County's highest priorities are client care and addressing the needs of our community. By joining CalMHSA in creating a new Semi-Statewide Enterprise Health Record (EHR), using Streamline Healthcare's SmartCare platform, Ventura County Behavioral Health (VCBH) is able to achieve both priorities. The new EHR will be more person and provider centered, services can be enhanced by decreasing the amount of time (estimated by CalMHSA to be 30%) providers are required to document services provided and other critical information into each client's record. The project includes a robust process of input from participant counties to ensure the system will allow VCBH stakeholder feedback to be incorporated and for staff to have additional time to provide enhanced services to the community.

This multi-county collaborative is capitalizing on the strength, knowledge, and experiences of over twenty (20+) counties in formulating a new EHR. The new EHR will meet the new CalAIM standards and will quickly adapt to the ever-changing State requirements. Additionally, it will allow staff to collect and report on meaningful outcomes and provide tools for direct service staff that enhance rather than hinder care to the clients they serve.

This is an opportunity for Ventura County to benefit from this larger collaborative bringing expertise, knowledge, and experience to this project under CalMHSA's leadership and the California Counties participating in this project. This project is highly innovative due to this unique opportunity to create a new EHR in the above manner. The County will have the ability to participate in an evaluation of the project inclusive of stakeholder perceptions of and satisfaction with the decision-making process, as well as formative assessments to iteratively improve the design and usability of the new EHR by utilizing Human-Centered Design approaches that include summative assessments of the user experience and satisfaction with the new EHR as compared to the existing EHR and user burden. Below is a list of current local stakeholder feedback on ideal EHR project goals:

- Stakeholder interests focus on ensuring the EHR can capture data that is necessary for client care and supports the most current DHCS requirements, that can change frequently, and/or changes due to new grant funds or projects in a user-friendly and efficient way.
- Stakeholder interests also focus on ensuring the EHR can support accurate, timely, and comprehensive reporting that supports both ongoing monitoring and required reporting.

CalMHSA has supported the above stated goals by keeping County needs at front of mind. The CalMHSA team seeks input from Counties and is responsive to new County requests or needs. While there have been times when input may have been sought later in the process than VCBH would like, CalMHSA exhibits a continuous quality improvement process and is making changes to frontload County involvement as the development of the EHR progresses.

Additional Stakeholder Engagement

1. In March 2023 VCBH staff created a weekly Super User group consisting of selected members from each clinic and contracted provider, approximately 170 individuals (staff, prescribers, and Contracted providers) participated. Super Users were early adopters to learn the new electronic health record (EHR) system and were being situated to provide their clinic or programs with an on the ground "SmartCare" trainer. As a resource for their clinic, they would be able to guide, share helpful hints, tips, and techniques.
    a. Overview Super User Responsibilities
        i. Learning the new system
        ii. Developing, Testing and Training on new workflows
        iii. Discovering onboarding and adoption stumbling blocks
        iv. Identifying features your staff are using (and not using)
        v. Being a training resource for your clinics/programs
2. VCBH sent out weekly updates on SmartCare to all Impacted participants before June 30, 2023.
3. VCBH staff created a VCBH specific Frequently Asked Questions document that was provided in the weekly updates.
4. During the pre-go live trainings VCBH Staff created VCBH specific presentations regarding SmartCare to keep stakeholders informed and learning.
5. A weekly meeting with Senior operations leadership including representatives from operations, billing and EHR met to address both needs, issues, concerns, and additional stakeholder engagement. This weekly meeting was discontinued in 2023 due to the fact that it had outlived its necessity.
6. To support stakeholder engagement, VCBH created a unique VCBH.org email address for AskSmartCare@ventura.org so that staff specific questions could be sent directly to the electronic health record staff to address issues and be responsive to needs.

2023-24 Update:

Enhancements to Local Processes and Efficiency through SmartCare

The implementation of SmartCare has both streamlined and challenged various workflows in Ventura County Behavioral Health (VCBH). By adopting SmartCare, the county has aimed to enhance efficiency and adapt to ever-changing regulatory demands. This section outlines the specific ways SmartCare impacts local processes, workflows, and efficiency, while highlighting both the improvements and ongoing limitations.

Streamlining Processes through CalMHSA's Centralized Updates

One of the primary benefits of participating in the SmartCare project is the centralization of updates managed by CalMHSA, which alleviates the need for county staff to dedicate resources to implementing programmatic and regulatory changes. For example, updates to required data collection are handled centrally, saving time and effort at the county level. However, this centralized approach has also posed challenges, including delays in implementation and inconsistencies in the final product, despite CalMHSA's efforts to incorporate feedback from participating counties

Addressing the Shortcomings of SmartCare

Several issues in the EHR have been addressed, although some critical gaps remain. For instance:

- **Bundling of Forms**: The system's limitations, such as the inability to bundle related forms (e.g., intake forms), are only partially mitigated by SmartCare's use of tracking protocols. This workaround, while functional, requires additional monitoring and manual effort to monitor an close flags.
- **Language Accessibility**: Supporting threshold languages, such as Spanish, remains a challenge. Staff are still required to scan paper documents, adding additional steps to the process and ongoing workload.
- **Consent Conflicts**: Divergent legal interpretations between Manatt (CalMHSA's legal counsel) and Ventura County Counsel have resulted in underutilization of SmartCare's consent features.
- **Group Notes**: Ongoing unresolved issues with Group Notes have persisted since SmartCare's implementation, leading to significant frustration among end users.
- **State Reporting**: Submitting state reports (e.g., CalOMS, PSC35, CSI, FSP) is hindered by high staff turnover at Streamline, persistent glitches, and unresolved system issues affecting both the user interface and data migration.
    - CalOMS – partially working
    - PSC35 – unable to submit due to system issues
    - CSI – unable to submit due to system issues
    - FSP - pending State testing

Stakeholder Engagement and Solutions

VCBH has engaged with stakeholders to address system issues and identify practical solutions. A May 16th meeting with Kris Watson and Brandon Franklin of CalMHSA led to a comprehensive

review of outstanding shortcomings, categorized under billing, quality, nursing/prescriber, and other EHR-related issues. This collaborative approach has been a step toward improving responsiveness and functionality, though progress remains slow.

VCBH utilizes the ServiceNow Ticketing System to manage IT service requests and incidents related to SmartCare at the local level. This system enables the EHR team to identify whether issues are user-related or system-based. If an issue cannot be resolved locally, the EHR team escalates it to the CalMHSA ticketing system for resolution.

VCBH issues a monthly Quality Care Bulletin for service providers, featuring a section that highlights updates on behavioral health initiatives affecting SmartCare, along with other relevant SmartCare information.

Innovative Training and Data Solutions

To improve user adaptability and workflow efficiency, VCBH has introduced a "Day in the Life" training program. This monthly initiative offers end users—both new and experienced—a platform to understand workflows, ask questions, and build foundational knowledge of SmartCare operations.

VCBH is developing a secondary data warehouse to address limitations in SmartCare by capturing essential data points required for reporting and daily operations.

It is challenging to determine who may have inappropriately accessed medical records in SmartCare. To address this, VCBH is utilizing Imprivata OneSign to enhance cybersecurity and ensure compliance with data governance requirements.

Progress Update and Identified Changes

1. Please describe your project progress from July 1, 2023, through June 30, 2024.

Throughout FY 2023-24, Ventura County staff worked diligently to support the rollout of SmartCare for both VCBH and CBO teams. By late summer 2023, all staff had completed orientation to the new EHR system and were receiving regular updates as the platform evolved to meet county requirements and DHCS specifications. Over the first year of implementation, staff across all levels grew more proficient with the system, adapting to its workflows and functionality.

To enhance onboarding and improve the user experience, the EHR team collaborated closely with Office Assistants, Clinicians, Prescribers, and Nurses by shadowing them during their daily operations. This hands-on approach allowed the team to identify workflow inefficiencies and informed the creation of a comprehensive training program. Mandatory in-person training was required for all new users, while the enhanced training program was offered as an optional resource for existing users. Many staff members participated, leveraging the opportunity to deepen their proficiency with the system and streamline their

workflows. This approach while effective, was costly and resulted in high staff costs during implementation which the County has addressed in year two.

Have any new staff been hired to support the implementation of this project, and if so, please provide position title(s) and role(s)/responsibilities.

VCBH has engaged a consultant to develop a secondary data warehouse to address gaps in SmartCare's functionality. This solution captures essential data points needed for reporting and daily operations, ensuring continuity and enhancing operational efficiency despite SmartCare's limitations.

- Enable BH Team to collect secondary data that is not collectable in SmartCare.
- Provide Performance and Productivity related Dashboards/reports.
- Build custom Data Marts to analyze BH service utilization by clients
- Custom dashboard/reports for Quality measures.
- Datamart to measure Clinician engagement with clients.

What is the status of onboarding to SmartCare any local CBOs you work with?

CBOs were onboarded, trained, and updated simultaneously with county staff to ensure a seamless transition. Some CBOs expanded their use of the county EHR, shifting from billing-only functionality to full utilization of SmartCare, requiring adjustments to their workflows. Billing-only CBOs now have greater capabilities and visibility within SmartCare compared to the previous system, necessitating additional training and workflow modifications. New CBOs joining Ventura's BHP are onboarded as either full-use or billing-only users, based on their specific needs.

Please describe your experience working with CalMHSA and other participating counties in this project. (Has your county used the CalMHSA collective dashboards or any LMS learning opportunities? Has your county used any county-specific dashboards created by CalMHSA, leveraged new reports/list pages or received assistance with State reporting requirements?)

During the first year of the SmartCare implementation, CalMHSA supported counties by providing training materials, updating the EHR, building reporting capabilities, and addressing operational needs. However, as the system was adopted, various issues and gaps were identified. In response, CalMHSA introduced mechanisms for counties to provide feedback, participate in the improvement process, and report ongoing concerns or required changes. Despite these efforts, progress on fixes and updates has been slow. As a result, VCBH has developed workarounds, communication strategies, training programs, and processes to meet provider needs and ensure seamless information collection.

VCBH actively participates in the weekly SmartCare Sys Admin Workgroup, a platform that fosters collaboration among counties using SmartCare. This forum enables counties to build relationships, share strategies for navigating the system, and support one another in problem-solving. Participants collaboratively propose solutions, discuss workflows and regulatory requirements, and present collective requests to CalMHSA, strengthening their ability to address shared challenges.

In terms of communication with CalMHSA, there is a need for more timely updates, particularly regarding new initiatives and DHCS implementations. In Q4 of FY23-24, Ventura County compiled a list of issues across various focus areas and shared it with the assigned CalMHSA account manager. While this effort helped prioritize key concerns, the majority of CalMHSA and Streamline resources were directed toward addressing billing issues, leaving Clinical and Quality/Medical Records concerns insufficiently addressed.

The CalMHSA Collective Dashboard has not yet been fully adopted by Ventura County. Initially perceived as a fiscal/billing tool to track services, charges, and claims, the dashboard has provided useful reports. However, some reporting elements do not align with Ventura County's preferred monitoring approach, such as the need to separate Billable and Non-Billable totals and address the overstatement of group service durations.

Additionally, several list pages within the system could be highly effective if their filtering capabilities functioned properly. For example, the Caseload (My Office) page only allows filtering by staff, which duplicates the functionality of the Caseload widget. A filtering option by Program would be far more useful for Clinic Administrators and Managers, enabling more efficient oversight and management.

State Reporting has faced significant challenges since the start of SmartCare's implementation due to several factors:

- **Limited Initial Knowledge:** Streamline initially lacked a comprehensive understanding of State requirements.
- **Staff Turnover:** High turnover rates at both CalMHSA and Streamline disrupted continuity and progress.
- **Training Challenges:** Multiple iterations were required to adequately train Sys Admin staff on the TEDS construct and concepts necessary for managing key State Reporting tasks, such as CSI and CalOMS.
- **County Variability:** The high degree of variability in how counties structure State Reporting data, driven by differences in contractor-county setups, made it difficult to accommodate the unique requirements of each county.

Throughout FY23-24, the VCBH EHR team has worked closely with CalMHSA and Streamline, holding weekly calls to address ongoing issues. While Kris Watson has been a strong advocate for VCBH, circumstances beyond his control have delayed progress, and significant work is still needed to ensure full system functionality.

2. Has your county experienced any changes in project implementation and/or local need since the submission of your Appendix for MHSOAC approval? What is/are the reason(s) for this/these change(s)?

No not applicable.

3. How does this change/these changes noted in #2 above impact or modify your project plan and/or timeline?

Not applicable.

CalMHSA's Internal Evaluation and Qualitative Analysis of the State of Electronic Health Records Across California Counties

CalMHSA partnered with IDEO, a global, human-centered design and research company with over 40 years of consulting experience working in social and government sectors. As reported in the 2023 Annual Report, IDEO conducted interviews with over 50 county staff, met with EHR and other analogous experts (e.g., digital storytellers, data visualization scientists and behavioral scientists), and completed an in-depth analysis of SmartCare to inform design strategies that align with user needs, promote transparent communication, augment decision-making and best practices and, through increased efficiency, reduce staff burnout and improve workforce retention. IDEO identified the following key needs in the previous project period:

- An improved EHR design that allows for a holistic view of patient data rather than siloed across different areas of the software
- Better facilitation of record keeping and sharing across the platform
- Improved utilization of automaticity and intentional pauses at moments to accurately capture structured data to reduce redundancy, disseminate key information and promote best practices while maintaining flexibility and trust amongst users
- Transparent dialogue and a disruption of bias patterns in the software so the data entered can promote equitable outcomes and care

During this project period, CalMHSA initiated or completed multiple initiatives that align with the needs identified by IDEO as well as the project aims / learning goals outlined in the subsequent section.

Data Automaticity: Toward the goal of reducing documentation burden and ensuring providers have current information available to support clinical decision making and care coordination, functionality was implemented that syncs clinical data across multiple documents within the EHR. For example:

- When a provider writes a progress note, they can add a newly identified problem to the client's problem list from within the note itself. The newly identified problem is automatically added to the client's problem list for viewing by others on the treatment team without the provider needing to duplicate the entry.

- A new psychiatry note was implemented, designed with county input (e.g., medical directors, nurses, prescribers, pharmacists). The note pulls recent and relevant data from other chart sources (e.g., current medications, labs, allergies, orders), allowing providers to access key medical information for clinical decision making. The note also allows providers to select what information is clinically relevant from recent session notes, allowing them to pull important medical information forward without having to retype.

EHR Functionality to Promote Client Safety and Clinical Best Practice:

- Client face sheets and reports (e.g., discharge, shift summaries, facility medication administration, medication reconciliation, appointments) were created that aggregate comprehensive data into a cohesive and holistic clinical presentation for providers.
- Mechanisms were implemented to ensure critical client information (e.g., legal holds, seclusion/restraints, medication reconciliation, drug interactions) are evaluated timely and routinely to enhance safeguards for patient rights and safety. For example, CalMHSA developed mechanisms for counties to track a client's legal hold status, which was iteratively improved to incorporate DHCS guidance. Providers can review key information, such as when the legal hold was last reviewed and the review outcome, helping them understand the client's progression through legal hold process, promoting efficient and timely review to ensure the provision of clinically appropriate care.

Collective Dashboards: Multiple counties identified dashboarding as a local need to support activities such as workflow management, monitoring, and outcomes tracking. CalMHSA launched PowerBI dashboards in February 2024 that transform raw EHR aggregate (non-PHI) data into actionable insights for counties. They display county-specific data on key indicators (e.g., population demographics and diagnoses, service utilization, program enrollment/discharges, billing processes), which can be used to inform program planning/oversight, decision-making through an equity lens and benchmarking system performance. Counties can also compare their performance to other counties (e.g., of similar size or region) as well as aggregate performance across all counties using the EHR for statewide benchmarking.

EHR User Support: CalMHSA instituted multiple platforms to provide continuous support to counties across EHR user roles/disciplines (e.g., clinicians, prescribers, administrators, contract providers, quality management, front desk and billing staff). Some resources are available 24 hours a day, seven days a week to ensure counties have access to information on-demand, as needed.

Chatbot: CalMHSA implemented an innovative, AI-driven technology that provides on-demand information retrieval to respond to EHR user support questions (e.g., on EHR functionality, billing requirements, etc.). Staff can access the Chatbot on their home page dashboard when they login to the EHR. Chatbot was used continuously throughout FY 2023-24, averaging around 4,000 messages every month (approximately 47,000 messages total).

EHR Knowledge Base Website: CalMHSA published and maintains a county-facing website that includes training materials, user guides, FAQs and tools to support counties in using the EHR. Website analytics for nine months in FY 2023-24 show active engagement:

- 36,000 active users viewed 425,000 website pages. The average number of pages viewed per user was approximately 12, and the average active engagement time spent on the site per session was around 5.7 minutes.
- Around 22,000 documents were downloaded by around 4,400 users, with two of the most common files being EHR Essentials (1,700 downloads, 1,200 users) and Clinical Workflow (1,100 downloads, 826 users). The average number of download events per user was around five.
- The top ranked page paths were Clinical Documentation (32,000 views) and Billing Documentation (14,000 views).

Helpdesk: The Helpdesk is available 7 a.m. to 7 p.m. (PST), Monday through Friday, to respond to user needs and requests. Helpdesk utilization data show active county engagement with this resource in FY 2023-24. During the initial EHR rollout in quarter 1, the total number of tickets (approximately 6,700) was nearly three times the remaining quarterly totals and then stabilized in quarters 2 through 4 (averaging around 2,100 tickets per quarter). This pattern suggests users benefitted most from Helpdesk support when the system was new.

County Shared Decision-Making Meetings: CalMHSA began facilitating shared decision-making meetings in quarter 3 of FY 2023-24 to obtain county input on improvements/ developments to the EHR system. Between March and June 2024, CalMHSA hosted five meetings on various topics (patient portal, crisis stabilization billing, supervisor document review processes, tracking client grievances and appeals, and EHR development prioritization). On average, around 55 individuals across 20 counties attended these meetings. Shared decision-making strategies will continue to be used to guide development efforts over time.

Meta-Tagging: In FY 2023-24, CalMHSA began working with counties to implement program meta-tagging, which is a process where counties define key attributes of each program such as service populations and intended outcomes. Meta-tagging allows counties to group programs with similar attributes – once fully adopted, it can be used for program planning as well as tracking outcomes across comparable programs within and between counties. As part of the initial rollout, meta-tagging has been used to streamline certain billing processes:

- Meta-tagging enabled CalMHSA to accurately identify the types of services provided through the programs and ensure appropriate billing codes and modifiers are applied. This process ensures precise billing and alleviates the need for counties to manually attach programs to rate schedules. Automating this task significantly reduced the time and inefficiency associated with updating potentially hundreds of rate records per program.
- CalMHSA developed an innovative process that integrates the service tables and rate schedules published by DHCS with each county's specific meta-tagging. This results in a comprehensive set

of rate records that is automatically uploaded into the county's SmartCare environments via a script. This streamlined approach significantly reduces the time required to implement critical billing updates, ensuring counties can operate more efficiently and effectively.

Evaluation Data/Learning Goals/Project Aims

CalMHSA contracted with the RAND Corporation to conduct a comprehensive evaluation of the project. RAND selected evidence-based EHR metrics grounded in measurement science that are precise, reliable and valid. To ensure a systematic evaluation of the migration to the new EHR platform, RAND is employing two measurement approaches:

1. A pre-post **user survey to measure user experience and satisfaction** of existing EHRs and the new EHR across all participating counties.
2. Pre-post **task-based usability testing** to obtain objective measures of EHR usage and burden (as measured by the length of time required to complete specific, common tasks in the EHR) before and after the migration to the new EHR.

The pre-phase measurements were collected and reported in the 2023 Annual Report. The timeline for completing the post-phase measurements was extended due to multiple DHCS policy changes that impacted county operations during this project period (e.g., documentation reform, payment reform), which contributed to an extended EHR implementation period. RAND will complete the post-EHR migration measurements and evaluation of project aims/learning goals outlined below at a future date. The evaluation will eventually allow for an assessment of how the transition to the new EHR resulted in changes to usability and user satisfaction.

Learning Goals/Project Aims
Quality ▪ Comprehensiveness of client care ▪ Efficiency of clinical practice ▪ Interactions within the health care team ▪ Clinician access to up-to-date knowledge
Safety/Privacy ▪ Avoiding errors (i.e., drug interaction) ▪ Ability to use clinical data for safety ▪ Personal and professional privacy
Satisfaction

▪ Ease of use ▪ Clinician's stress level ▪ Rapport between clinicians and clients ▪ Client's satisfaction with the quality of care they receive ▪ Interface quality
Outcomes ▪ Communication between clinicians and staff ▪ Analyzing outcomes of care ▪ System usefulness ▪ Information quality

Program Information for Individuals Served

This project focuses on transforming current EHR systems and processes counties use for the provision of behavioral health services. Accordingly, we have not estimated the number of individuals expected to be served annually. As noted previously, the participating counties in the Semi-Statewide Enterprise Health Record project are collectively responsible for serving the population of Medi-Cal members who need specialty mental health and/or substance use disorder treatment services among approximately 35% California's Medi-Cal members.

Regarding specific project information on individuals to served, this project focuses on transforming the current EHR *system and the processes* California counties use for the provision of behavioral health services rather than directly testing an innovative approach to *service delivery*.

Budget and Annual Expenditures

County partners: Please provide an update on your current budget and expenditures. Please create a budget table and use the same budget categories submitted in your approved Appendix as included in the EHR INN project proposal as a reference for what budget categories to include, for example:

Salaries & Benefits expenses decreased by 105% from last year compared to submitted and approved budget ($43,154.73). The decrease was due to fewer staff being assigned to the ongoing work of the EHR development and more in line with what was originally budgeted. A decrease in overall staff hours were billed toward to implementation project. Majority of hours included in FY22-23.

Please see the below budget versus actual expenses variance for FY23-24 by line items.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

	BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY		ACTUAL EXPENSES	Variance	Increased /Decreased %	Reason for Increase/ Decrease
COUNTY	Ventura County		July1,2023-June30,2024			
EXPENDITURES		a	b	c=b-a	d=c/a	
	PERSONNEL COSTS (salaries, wages, benefits)	FY 23-24	FY 23-24			
1	Salaries	257,885	297,412.91	39,528		
2	Direct Costs (Benefit)	130,327	128,325.12	(2,002)		
3	Indirect Costs (15% of Salaries and Benefit)	58,232	63,860.70	5,629		
4	**Total Personnel Costs**	**446,444**	**489,598.73**	**43,154.73**	10%	Less payroll hours toward to implementation plan since majority of payroll hours in FY22-23
	OPERATING COSTS*	FY 23-24	TOTAL			
5	Direct Costs	20,334	10,340.23	(9,994)		
6	Indirect Costs (15% of Direct Cost)	3,050	1,551.03	(1,499)		
7	**Total Operating Costs**	**23,384**	**11,891.26**	**(11,492.74)**	-49%	Office space, communication expenses and office supplies are slightly lower than budgeted.
	NON-RECURRING COSTS (equipment, technology)	FY 23-24	TOTAL			
8						
9						
10	**Total non-recurring costs**	-				
	CONSULTANT COSTS/CONTRACTS	FY 23-24	TOTAL			
11	Direct Costs	236,154	96,054.02	(140,100)		
12	Indirect Costs					
13	**Total Consultant Costs**	**236,154**	**96,054.02**	**(140,099.98)**	-59%	Majority of consultant charges paid in FY22-23
	OTHER EXPENDITURES (explain in budget narrative)	FY 23-24	TOTAL			
14						
15						
16	Total Other Expenditures	-				
	EXPENDITURE TOTALS	FY 23-24	TOTAL			
	Personnel (total of line 1)	257,885	297,412.91			
	Direct Costs (add lines 2, 5, and 11 from above)	386,815	234,719.37			
	Indirect Costs (add lines 3, 6, and 12 from above)	61,282	65,411.74			
	Non-recurring costs (total of line 10)	-				
	Other Expenditures (total of line 16)	-				
	TOTAL INDIVIDUAL COUNTY INNOVATION BUDGET	705,982	597,544.02			
	CONTRIBUTION TOTALS**	FY 23-24	TOTAL			
	County Committed Funds	705,982	597,544.02			
	Additional Contingency Funding for County-Specific Project Costs					
	TOTAL COUNTY FUNDING CONTRIBUTION	705,982	597,544.02	(108,438)	-15%	

Appendix H: AD-48: Stakeholder Collaboration

Current Status: *Active* **PolicyStat ID:** *7398775*

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Origination:	*9/5/2011*
Effective:	*9/13/2017*
Last Approved:	*9/13/2017*
Last Revised:	*9/13/2017*
Next Review:	*12/1/2023*
Owner:	*Courtney Lubell*
Category:	*Administration*
Affects:	*ALL DIVISIONS*

AD-48: Stakeholder Collaboration

AFFECTS

ALL DIVISIONS

LEVEL

1

PURPOSE

To provide information on how Ventura County Behavioral Health (VCBH) collaborates with stakeholders regarding programs, services and policies.

DEFINITION(S)

Stakeholder: For this policy, stakeholders are clients, family members, community members, VCBH employees as well as outside agencies and organizations whose interests are affected by the Behavioral Health system and whose activities may likewise affect the system.

Mental Health Services Act (MHSA): The Mental Health Services Act is a voter approved initiative that provides for the development, through a stakeholder process, of a comprehensive approach to providing community based mental health services and supports for California residents.

Committee: A committee is a group officially delegated to consider, investigate, act on, or report on some matter.

Subcommittee: A subcommittee is a group appointed by a main committee for ongoing monitoring, review and planning of and for a specific program, division, entity or agency and then report their findings back to the main committee where decisions concerning findings are made.

Work-Group: A work-group is two or more individuals, who function as a team, and work towards a common goal. Their duties may include conducting research and making recommendations.

Focus Group: A focus group is a group that is scheduled to discuss a specific topic with the goal of receiving feedback from interested stakeholders for planning and decision-making.

Task Force: A task force is a temporary group established to work on a single defined task or idea.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

POLICY

Ventura County Behavioral Health (VCBH) is committed to addressing the mental health as well as

PROCEDURE

the alcohol and drug prevention and treatment needs of a diverse population and as such supports and facilitates multiple pathways through which stakeholders play an integral role in providing input regarding programs, services and policy.

1. Stakeholder involvement is accomplished through various approaches, including:
    1. Advisory Boards and their committees/sub-committees, work-groups and task forces.
    2. VCBH committees, focus groups, workgroups, and task forces.
    3. MHSA Component Planning committees and workgroups.
    4. Interagency collaborations.
    5. Meetings with staff and their representing Union(s).
    6. Consumer and family groups.
2. Advisory Boards- Behavioral Health Advisory Board (BHAB):
    1. The BHAB is made up of stakeholders appointed by the Board of Supervisors and functions in an advisory capacity to the County of Ventura Behavioral Health Director and Board of Supervisors.
        1. It operates under bylaws that are approved by the County Board of Supervisors and its role is defined in Welfare and Institutions Code 5604.2.
        2. It also serves an important role in facilitating public discussion of Mental Health Services Act (MHSA) plan approval, provides feedback prior to the required 30-day posting and then conducts the Public Hearing.
            1. The BHAB may approve the plan to send to the Board of Supervisors, or return it to VCBH with recommended changes.
            2. The BHAB has authority to approve the plan before submission to the Board of Supervisors for final approval.
    2. Advisory board sub-committees, work-groups and task forces are appointed by, and may include members from, their respective board as well as other interested stakeholders.
        1. Each advisory board sub-committees operate under bylaws, have standing meeting times, keep minutes and report regularly to their respective board(s).
3. Mental Health Services Act (MHSA): Community Program Planning Committees and Workgroups includes representation of affected populations in MHSA program and services planning.
    1. VCBH will provide active outreach to ensure key stakeholders are included in the development of programs and services so that they are reflective of the needs of the population to be served.
    2. VCBH MHSA Committees:
        1. The MHSA department, MHSA Evaluation Committee, and MHSA Planning Committees lead the community planning and review processes for all MHSA components.

2. MHSA Planning Committee's mission is to review new program ideas, and recommend filling program gaps and or goals based on the community planning process.
3. MHSA Evaluation Committee's mission is to review MHSA program performance outcomes, stated program and component goals, cultural competency and penetration rates, fiscal impact, and client satisfaction surveys. The committee makes recommendations to VCBH based on its review with an annual assessment.
4. VCBH presents committee recommendations and all reports to the BHAB for review.

3. MHSA Issue Resolution Advisory Committee:
    1. The VCBH MHSA Stakeholder Issue Resolution Process allows stakeholders who have issues and concerns with an MHSA funded component, program or process to file an issue resolution request. Refer to VCBH Policy QM-18: Person in Care Problem Resolution Processes.
        1. If the issue cannot be resolved to the stakeholder's satisfaction at the Division Manager or Administrative Services Manager level, the MHSA Issue Resolution Advisory Committee will review the issue and provide recommendations to the VCBH Director.

4. Cultural Equity Advisory Committee:
    1. The Ethnic Services Manager leads the Cultural Equity Advisory Committee.
    2. The committee is comprised of mental health and alcohol and drug department staff, key stakeholders from community and faith based organizations, other county and city departments and individuals from the community at-large.
    3. The Cultural Equity Advisory Committee's mission is to ensure that mental health and alcohol and drug programs services are responsive in meeting the needs for care of diverse cultural, linguistic, racial and ethnic populations.
    4. The committee actively addresses the conditions that contribute to and are indicators of the need for appropriate and equitable care.
    5. The Ethnic Services Manager provides the Cultural Equity Advisory Committee's recommendations to the Ventura County Behavioral Health for review and consideration.
5. Focus Groups
    1. VCBH convenes focus groups to provide a forum for interested stakeholders to share their thoughts, ideas and suggestions regarding program development, service provision and community service need.
    2. Information on the meeting times and places is communicated via posted notices on the VCBH website, flyers, newspaper notices, and/or word of mouth through various community organizations and non-profits.
6. Topic Specific Task Forces and Workgroups
    1. Topic specific task forces and workgroups operate under the rules of their respective bodies of authority.
        1. A task force serves a temporary function.
        2. A workgroup may serve a temporary or long term function depending on the nature of the assignment.

2. Their respective groups appoint the participants and each group shares a common goal and/or task.
3. They may provide reports to their bodies of authority where the information is reviewed and decisions made.

7. Interagency and Community Based Organizations Collaboration
    1. VCBH encourages and facilitates interagency collaboration.
    2. Staff representing VCBH on committees, sub-committees or other collaborative forums with outside organizations or agencies, does so with the approval of their immediate supervisor and function as a representative of VCBH.
        1. Depending on the nature of the collaboration, approval may also be required from the Division Manager and/or Director.
    3. Committee status reports, work products and feedback will be shared with the Supervisor, Managers and/or Directors as appropriate.
8. Employees and Contract Physicians as Stakeholders
    1. VCBH employees and contract physicians voice concerns and provide input through various venues:
        1. Participation in VCBH committees, workgroups, task forces/focus groups that affect organizational decisions.
            1. Time limited focus group/task forces may also be created to determine staff/contract physician needs.
        2. Participation in interagency collaboration, when approved.
        3. Meeting - clinical team meeting, staff meetings and Town Halls.
        4. Informal conversations with managers.
        5. Annual performance evaluations.
        6. Anonymous surveys.
9. Consumer and Family Groups
    1. Feedback is encouraged from other Stakeholder groups, such as National Alliance on Mental Illness (NAMI), United Parents and the Client Network through direct consumer/family contact and by encouraging their participation in the BHAB as well as the subcommittees, workgroups and task forces.
    2. Feedback is obtained from the VCBH Transformational Liaisons.
    3. The VCBH Outcome System measures quality of care as well as the perception of care and are obtained from both families and clients.
        1. Perception of Care Surveys are collected at intake, annually and at discharge. This survey assesses, among other things, client/family satisfaction; their view on the quality and environment of care; their view on their involvement in the process.
    4. VCBH's Patients Rights' Advocate whose function is to provide information and investigate concerns. Per Policy AD 09: Patients' Rights.
    5. Consumers may also voice their views/concerns through the grievance process.
10. The following are additional goals of any stakeholder and interagency collaboration:

1. Outreach to the community to involve stakeholders early in the planning process.
2. Engage served and underserved clients as well as engage organizations and agencies who represent or who can report on the interests of these populations.
    1. The body should reflect the cultural and ethnic diversity of our county.
3. Provide education to the community on understanding the mental health system and how individuals can access services.
4. Receive suggestions on improving care and access.
5. Foster a sense of collaboration and support.

REFERENCE

WIC 5602, 5604.2, 5848
Health and Safety Code 11805 and 11998.1
CCR Title 9, Division 1, Chapter 14, Section 3200.270; 3300; 3315
MHB Bylaws; ADAB Bylaws
QM-18: Person in Care Problem Resolution Processes
AD 09 Patients' Rights

Attachments

No Attachments

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Appendix I: QM-18 Person in Care Problem Resolution Processes

POLICY

QM-18: Person in Care Problem Resolution Processes

Published 5/1/2024

Policy Category:	Quality Care	Affects:	All Divisions
Owner:	Lee, Karen	Origination Date:	2/22/2009
Policy Level:	2 - Internal and External	Last Reviewed andApproved:	5/3/2023

POLICY: Ventura County Behavioral Health (VCBH) accepts, monitors, and resolves all grievances and appeals regarding the delivery of behavioral health services in a timely and compliant manner.

PURPOSE: To provide guidance on appropriate procedures and timeframes for people in care problem resolution processes.

DEFINITIONS

TERM	DEFINITION
Appeal	A review by the Contractor of an adverse benefit determina
Authorizing Staff	VCBH staff who are designated to authorize services for Th Out of plan services, private providers, etc.
Discrimination Grievance	A complaint concerning the unlawful discrimination on the including sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status
Drug-Medi-Cal Organized Delivery System (DMC-ODS)	A continuum of care system for providing substance use di provide SUD treatment services to members in counties that
Expedited Appeal	An Expedited Appeal can be requested when the beneficiar standard appeal resolution process would seriously jeopard regain maximum function. This appeal may be submitted or resolved within 72 hours of Ventura County Behavioral Health
Grievance	Verbal or written expression/complaint of dissatisfaction about Determination & Grievance may include, but not limited to: • The quality of care or services provided. • Aspects of interpersonal relationships such as rudeness of • Failure to respect the person's rights regardless of whethe • A person's right to dispute an extension of time proposed Organized Delivery System (DMC-ODS) Plan to make an au
Mental Health Services Act (MHSA) Issue	An issue that involves an MHSA program, component or pr care.
Notice of Adverse Benefit Determination (NOABD)	A letter that provides information to people with Medi-Cal the Medi-Cal program.
Peer Support Services (PSS)	Culturally competent individual and group services that pro sufficiency, self-advocacy, development of natural supports such as group and individual coaching to set recovery goal relapse, empower members through strength-based coachi members and their families about their conditions and the with the member or significant support person(s) and may services can include contact with family members or other c focus on the treatment needs of the member by supporting support services are based on an approved plan of care and services include one or more of the following service comp provided in a supportive environment in which members an solving skills in order to help the members achieve desired members in the areas of socialization, recovery, self- sufficie maintenance of skills learned in other support services. 3) E and coaching to encourage and support members to partice supporting members in their transitions and supporting members 4) Therapeutic Activity, which means structured non-clinical recovery, wellness, self-advocacy, relationship enhancemen and the maintenance of community living skills to support their communities. These activities may include but are not self-advocacy; resource navigation; and collaboration with the members, family members, or significant support persons.
	4) Therapeutic Activity, which means structured non-clinical recovery, wellness, self-advocacy, relationship enhancemen and the maintenance of community living skills to support their communities. These activities may include but are not self-advocacy; resource navigation; and collaboration with the members, family members, or significant support persons.
Quality Management Action	Committee charged with reviewing, evaluating, and recom

PROCEDURE

Initiation

1. A person can file a Grievance or Appeal (including expedited appeals) at any time by contacting the VCBH Quality Management Department or the VCBH Patients' Rights Advocate Office.
   - The person can present evidence and allegations of fact or law, in person or in writing.
   - The person can examine the medical records, or any other document or record considered pertinent to the determination before and during the Appeal process. The documents are available in advance of the resolution timeframe and free of charge.
   - If the person needs help filing a Grievance or Appeal, VCBH provides reasonable and culturally competent assistance. For information about language assistance, refer to CA-48: Use of Interpreters/Certified County Employee.
   - **For Substance Use Disorder (SUD) Only:** A person may file Grievances regarding a Substance Use Disorder Facility and submit counselor complaints directly with the Department of Health Care Services Substance Use Disorder Compliance Division at the toll-free number 1- 877-685-8333 or online at http://www.dhcs.ca.gov/individuals/Pages/Sud-Complaints.aspx.
2. If a person in care receives a Notice of Adverse Benefit Determination (NOABD), the person has the right to file an appeal.
   - Refer to QM-18 Notice of Adverse Benefit Determination Operational Guideline 2019 for guidance on various types of NOABDs and required enclosures.
   - A person may receive the NOABD from VCBH for any of these reasons: ■ Authorization denial of a request for services
     - Denial of payment for a service
     - Determination that a person is not eligible for services with VCBH ■ Change in services with a negative impact to a person in care
     - Reduction, suspension, or termination of previously authorized service
     - Delay in processing authorization of services ■ Failure to provide timely access to services
     - Dispute of a person's financial liability for services ■ Failure to timely resolve grievances and appeals
   - **NOABD Timeframes:** VCBH mails the notice within the timeframes below.
     - **For termination, suspension, or reduction** of a previously authorized specialty mental health and/or DMC-ODS service, at least **10 calendar days** before the date of action, except as permitted under 42 CFR §§ 431.213 and 431.214.
     - For denial of payment, at the time of any action denying the provider's claim; or for decisions resulting in denial, delay, or modification of all or part of the requested specialty mental health and/or DMC-ODS services, within **2 business days** of the decision.
     - VCBH also communicates the decision to the affected provider within **24 hours** of making the decision.
   - **Appeal Timeframe:** Following receipt of the Notice of Adverse Benefit Determination, the person has **60 calendar days** from the date on the notice in which to file a request for an appeal (including an expedited appeal).
3. Grievances and appeals (including expedited appeals) received are kept confidential.
4. Grievances and appeals (including expedited appeals) are not part of a person's medical record.

Local Resolution

1. VCBH Quality Management Staff logs all Grievances and Appeals within **1 working day** from receipt.
   - **MHSA Issue Local Resolution:** Quality Management Staff investigates and resolves all MHSA Issues in compliance with the timeline and notification requirements outlined in this policy. If the issue filer does not agree with the local resolution, the issue filer submits an appeal to Mental Health Services Oversight and Accountability Commission (MHSOAC), California Mental Health Planning Council (CMHPC), or California Department of Health Care Services (DHCS).
   - **Note:** Requests for a second opinion or a change of provider, which are not otherwise intended as a grievance or an appeal, are processed as outlined in CA-42: Request for Second Opinion/Change of Provider.
2. VCBH sends an Acknowledgement of Receipt of Grievance or Appeal Letter within **5 calendar days** from receipt, along with the appropriate QM-18 Nondiscrimination Notice and QM-18 Language Assistance Taglines.

3. To avoid any conflict of interest, all Grievances and Appeals are reviewed and investigated by staff who have not been involved in any previous level of review or decision making regarding the Grievance or Appeal under review.
    - When the Grievance or Appeal is regarding a clinical issue or the denial of an Expedited Appeal, a health care professional with clinical expertise in treating the person's condition reviews the case and makes a determination.
    - **Discrimination Grievances:** The VCBH Senior Compliance Manager acts as the Discrimination Grievance Coordinator responsible for ensuring compliance with federal and state nondiscrimination requirements and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law.
    - **Peer Support Services (PSS) Grievances:** VCBH reviews and tracks all PSS Grievances in the same manner as all other Grievances related to VCBH staff.
        - VCBH notifies California Mental Health Services Agency (CalMHSA) of all PSS Grievances via email at PeerCertification@calmhsa.org.
4. **Grievance Resolution Timeframes:** VCBH reviews and resolves all Grievances within 90 calendar days from receipt and sends Notice of Grievance Resolution Letter, along with the appropriate QM-18 Nondiscrimination Notice and QM-18 Language Assistance Taglines upon resolution.
    - **Timeframe Extension:** Timeframe extension for an **additional 14 calendar days** is allowed if the person requests it or VCBH shows that there is need for additional information and how the delay is in the person's best interest. If VCBH initiates an extension, it must make reasonable efforts to give the person prompt oral notice of the delay as well as provide in writing the reasons for the extension within **2 calendar days** of the Grievance Resolution decision. The written NOABD (Grievance and Appeal Timely Solution) letter must inform the beneficiary of their right to file a grievance if they disagree with the VCBH decision.
    - VCBH notifies those providers cited by the person or involved in the grievance of the final disposition of the person's grievance, as appropriate.
    - **Substance Use Disorder (SUD) Only:** VCBH provides the results of all complaints warranting investigations to DHCS by secure, encrypted e- mail to MCBHOMDMonitoring@dhcs.ca.gov withing 2 business days of resolution.
5. **Appeal Resolution Timeframes:** VCBH reviews and resolves all standard Appeals within **30 calendar days** from receipt and expedited Appeals within **72 hours** from receipt. VCBH sends the Notice of Appeal Resolution Letter, along with a copy of the appropriate QM-18 Nondiscrimination Notice, QM- 18 Language Assistance Taglines, and QM-18 NAR Your Rights upon resolution.
    - **Timeframe Extension:** Timeframe extension for an **additional 14 calendar days** is allowed if the person requests it or VCBH shows that additional information is needed and how the delay is in the person's best interest. If VCBH initiates an extension, it must do the following:
        - Make reasonable efforts to give the beneficiary prompt oral notice of delay.
        - Within **2 calendar days** of making the Appeal Resolution Decision, provide the beneficiary with a written NOABD (Grievance and Appeal Timely Resolution) letter of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if they disagree with the decision.
        - Resolve the appeal as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.
    - **Expedited Appeal Denials:** If VCBH denies an Expedited Appeal, the person or the person's representative must be notified orally as soon as possible. A written notice of denial of the Expedited Appeal is sent within **2 calendar days** to the beneficiary and the Appeal will be considered under standard Appeal.
    - VCBH notifies those providers cited by the person or involved in the appeal of the final disposition of the person's appeal, as appropriate.
    - **Note:** If the Appeal or Expedited appeal process has been exhausted, people may file for a State Fair Hearing no later than **120 calendar days** of the Notice of Appeal Resolution, as described in QM-18 NOABD Know Your Rights and QM-18 NAR Your Rights.
6. Decisions on Grievances and Appeals (including Expedited Appeals) take into account all documents, records and other information submitted by the person in care or the person's representative, without regard to whether the information was submitted or considered in the initial adverse benefit determination.

Continuation of Benefits during Appeals

1. The person in care has the right to continue their benefits during the Appeal or State Fair Hearing resolution process.
2. Benefits continue through the Appeal or State Fair Hearing process only if all the criteria below are met:
    - The person in care requests continuation of benefits within 10 calendar days of Ventura County Behavioral Health sending the Notice of Adverse Benefit Determination (NOABD).
    - The person in care submits an appeal or requests a State Fair Hearing within **60 calendar days** from the date of the Notice of Adverse Benefit Determination (NOABD).
    - The request involves the termination, suspension, or reduction of previously authorized services.
    - The services were ordered by an authorized provider.
    - The period covered by the original authorization has not expired.
    - Benefit continuation ends when the person withdraws the appeal or request for State Fair Hearing or when the State Fair Hearing Office issues an adverse hearing decision.

Quality Monitoring and Reporting

1. In compliance with Federal and State reporting requirements, VCBH tracks and reports, as required, all appropriate data on Grievances, Appeals, and State Fair Hearings to the California Department of Health Care Services (DHCS).

2. To support training and operational excellence efforts, Quality Management reports trends and applicable data analyses of Grievances, Appeals, and State Fair Hearings to the Quality Management Action Committee (QMAC) on an annual basis, at a minimum.

Policy References

☐ Reference Link

Drug Medi-Cal Organized Delivery System (DMC ODS) Standard Agreement: Exhibit A Attachment I DMC-ODS Exhib
2022-27 MHP Contract Exhibit A PSS Boilerplate and Exhibits B-E
MHSA County Performance Contract Exhibits AD-09: Patients' Rights
Cal. Code Regs. Tit. 9, § 1850.205 - General Provisions CFR Title 42, Section 438.400-438.421
Behavioral Health Information Notice No: 22-036 MHSUDS INFORMATION NOTICE NO.: 18-010E
CA-40: Initial Informing Materials
CA-48: Use of Interpreters/Certified County Employee CA-42: Request for Second Opinion/Change of Provider CA-01: Plan Member Enrollment
Behavioral Health Information Notice No.: 22-070

Culturally and Linguistically Competent Policies

VCBH is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. **All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department.** To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual's preferred language or mode of communication (i.e., assistive devices for blind/deaf). **Treatment teams will assess for, consider and work to mitigate all relevant cultural and/or linguistic barriers, as applicable.**

Appendix J: Full-Service Partnerships Outcomes Report

Full-Service Partnerships Outcomes Report

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

FY 2023-2024

What are FSP Programs?

Under the Mental Health Services Act (Prop 63), Community Services and Supports (CSS) component, Full-Service Partnership (FSP) programs provide intensive wellness and recovery-based services for previously unserved or underserved individuals with serious mental illness (adults and older adults) or severe emotional disturbances (children and youth) that would benefit from an intensive wraparound service program as they seek to achieve their individualized treatment goals. The MHSA has established a standard that 51% of all CSS funding be dedicated to these programs.

Why is this Important?

At Ventura County Behavioral Health (VCBH), the foundation of FSPs lies in a "whatever it takes" approach to help individuals on their path to recovery and wellness. FSPs embrace client-driven integrated services and supports that include treatment, case management, transportation, housing, crisis intervention, education, vocational training and employment services, as well as socialization and recreational activities. Unique to FSP programs are a low client-to-staff ratio, 24/7 Personal Service Coordinator (PSC) availability, and a treatment approach that employs, as the name implies, a "partnership" between consumers, mental health staff, peers and community-based service providers. Embedded in FSP programs is a commitment to deliver services in ways that are culturally and linguistically responsive and appropriate.

Data Collection and Reporting System (DCR)
FSP providers collect client self-report data, including the Partner Assessment Form (PAF), Quarterly Assessments (3Ms), and the Key Event Tracking (KET) forms. These self-report data are collected initially in VCBH's Electronic Health Records system and subsequently uploaded into the California Department of Health Care Services (DHCS) Data Collection & Reporting System (DCR).

In a typical year the department downloads outcome data from the DCR into the Enhanced Partner Level Data Templates in order to align with other county outcome reporting. However, since switching electronic health records in July 2023, there have been challenges with submitting data to the DCR. Ventura is one of several counties with this issue and there are many entities working to find a resolution. Therefore, DCR data from FY 23-24 cannot be utilized. Considering the limitations, the Quality Department has utilized other data to demonstrate impact of services and changes in function for FSP clients in FY 23-24.

Demographics

Table A1 presents demographic information for the *unduplicated* number of partners served in a VCBH FSP program within FY23-24. As illustrated, VCBH served a total of 472 partners; served is defined as having billed services rendered to the partner within the fiscal year. There were a total of 531 partners served in FY23-24 with 472 unique Adult, Older Adult and TAY partners and a total of 59 unduplicated youth partners served in FY23-24 (*Note*. 13 youth were part of Insights and 53 from Youth & Family FSP program with an overlap of 8 youth between the two programs in FY23-24; these youth partners will be discussed later in the youth FSP section).

As illustrated in Table A1, we have partner demographic information for Age Group, Sex, Sexual Orientation, Employment Status, Ethnicity, Race, and Preferred Language. These data are extracted from VCBH's Electronic Health Records (EHR) system based on the data that is collected. There are a number of data points that VCBH does not currently collect, including partner Veteran status and is not presented in this report.

Table A1. FY23-24 FSP Partner Demographics for TAY, Adults, and Older Adults (unduplicated client count)

Demographics (N = 472 unduplicated clients)		
Category	**N**	**%**
Age Groups Served (n = 472)		
0-15	--	--
16-25	36	7.8%
26-59	278	59.0%
60+	158	33.2%
Sex/Gender (n =472)		
Female	201	42.6%
Male	271	57.4%
Transgender	--	--
Sexual Orientation (n = 72)		
Bisexual	3	4.0%
Heterosexual	53	74.0%
Decline to answer	1	1.0%
Not Reported/Unknown	15	21.0%
Ethnicity (n = 452)		
Hispanic/Latino	169	37.0%
Non-Hispanic	256	57.0%
Unknown/Unreported	27	6.0%
Primary Language (n = 465)		
English	435	93.5%
Spanish	26	5.7%
American Sign Language (ASL)	1	0.2%
Other/Not Reported/ Unknown	3	0.6%

Note. Data based on VCBH Electronic Health Record

Please refer to section 4 of the Annual Update for additional information on FSP partners and the various programs that serve them within the county.

Additional Descriptive Information on FSP Clients

One hundred and thirty-nine (139) clients were newly enrolled in a designated FSP program for FY23-24; with approximately 337 rollover clients (including 4 duplicate clients who were discharged and re-enrolled within the same fiscal year).

The average length of service for Adult/Older Adult FSP clients was 3.5 years served with a range from 0.2 years to over 33 years in treatment, while the average length of service for youth FSP clients was 0.6 years in treatment with a range between 0.1 and approximately 4 years in treatment.

FSP TAY, Adult, and Older Adult Clients (Outcomes)

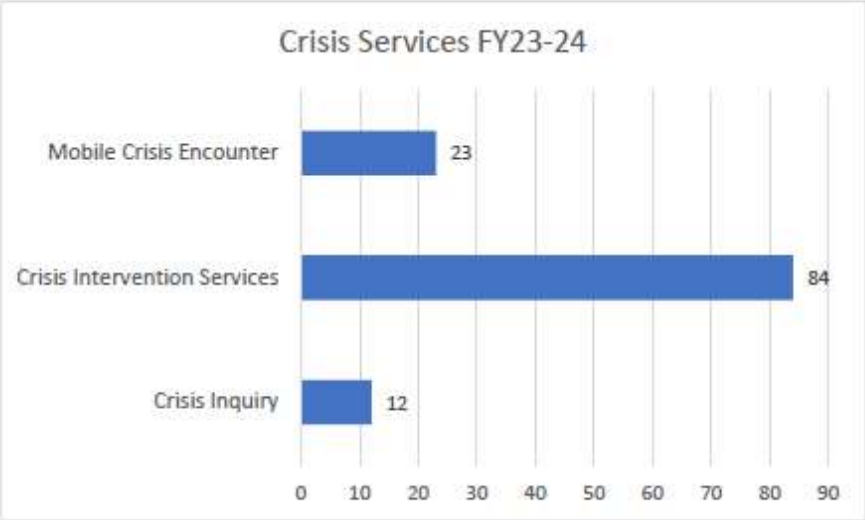
The following section presents outcomes for partners who received services in FY23-24. Due to the transition to a new EHR, the current report presents data on partners who were served for the one fiscal year (FY23-24). Future reports will aim to provide data over time on partners with at least two points of data. Thus, the outcomes presented here are limited to what the data team could extract from the EHR, including length of service, hospital admissions, number and types of crisis services, beneficiary satisfaction (for Adult/Older Adult partners).

Complete and accurate self-reported data on arrests, employment, or education from the PAF, 3Ms or KETs are unavailable and thus will not be presented in this year's report.

Partner Number of Crisis Events

Figure A1 displays crisis-related services for FSP partners for events addressed by VCBH's Access and Crisis 24/7 Line. Crisis-related services pertain to events that the crisis team responded to either through a mobile team dispatch or other intervention services (e.g., via telehealth or telephone). As illustrated, there were 119 crisis-related services for 54 unique clients for an approximate average of 2.20 crisis services for FY23-24.

Figure A1.



Note. Data based on EHR billed service records for 54 unique FSP clients

Partner Number of Therapy Services

Figure A2 displays the various billed therapy services for FSP partners in FY23-24 extracted from VCBH's EHR. As displayed, there were a total of 5,115 therapy services with the most services for 'therapy with a patient'. On average FSP clients were receiving approximately 25 therapy-related services in FY23-24.

Figure A2.

Note. Data based on EHR billed (with complete status) service records for 202 unique FSP clients

Partner Hospital Admissions

Table A2 reports the number of psychiatric hospitalizations and number of days hospitalized for partners who were enrolled in an FSP Program at VCBH in the FY23-24 service year and were hospitalized in FY23-24 compared to those same clients who were hospitalized in FY22-23 (from the same cohort). Hospitalization data were extracted from VCBH's electronic health record (EHR) system and reflects only the hospitalizations that VCBH has a record of; thus, it may not reflect all hospitalizations if VCBH was not notified of a non-Medi-Cal billed stay.

Based on this data for FY23-24 FSP clients, there were 126 partners with 269 hospital admissions (for a total of 4,043 days hospitalized) compared to 279 hospital admissions for 133 partners (with a total of 4,549 days hospitalized) in FY22-23 from the same cohort (see Table A2). A slight decrease in the number of psychiatric hospitalizations in FY23-24 was observed; of note, some partners had hospitalizations that began in FY22-23 and carried over in FY23-24.

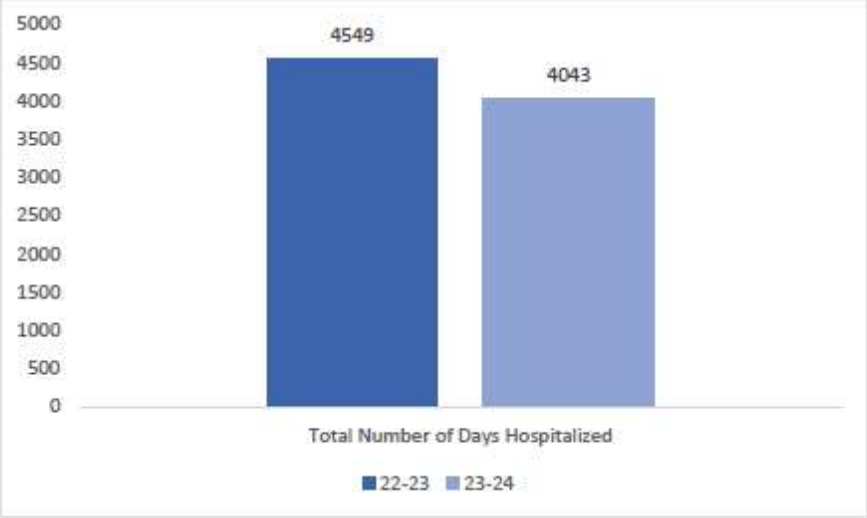
Table A2. Partner Psychiatric Hospitalizations

Partners in FSP who experienced psychiatric hospitalizations					
1 year before (Baseline: FY22-23)		Current: FY23-24		Percent Change from Baseline	
# of hospital admissions	# of days hospitalized	# of hospital admissions	# of days hospitalized	Percent Change in # of hospital admissions	Percent Change In # of Days Hospitalized
279	4,549	269	4,043	-3.9%	- 11.0%

Note. Data based on VCBH's EHR

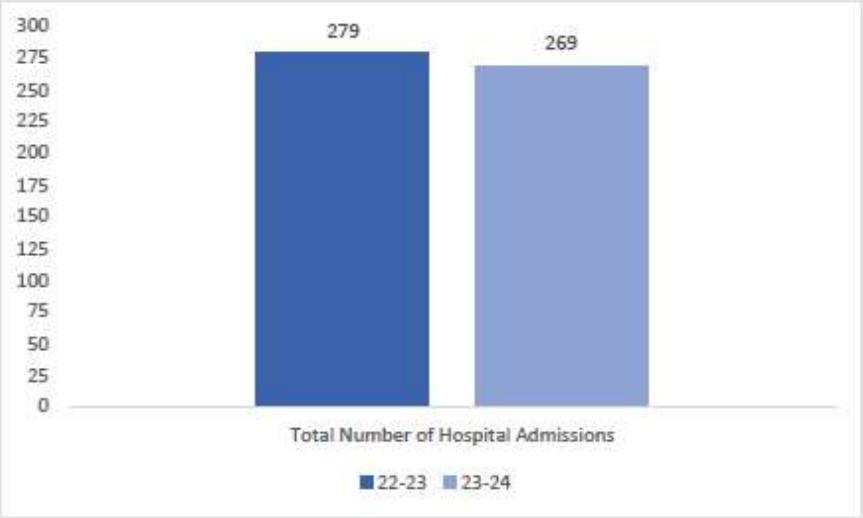
Figure A3 reports VCBH's data on partner hospitalizations. Figure A3 displays the cumulative total number of days hospitalized for partners who were served by a VCBH FSP program in FY23-24, compared to those clients' hospitalization in FY22-23. Although VCBH served a significant number of rollover partners (from FYs 22-23 to 23-24), a small portion of the total served in FY23-24 may have been newly established partners for the year; thus, this may be part of the reason for the result pattern observed in Figures A3 and A4.

Figure A3. Total Number of Days Hospitalized



Note. Data based on VCBH's EHR.
Figure displays cumulative total number of days hospitalized for partners served in FY23-24 and FY22-23 (for comparison).

Figure A4. Number of Partner Admissions to the Hospital



Note. Data based on VCBH's EHR.
Figure displays the total number of hospital admissions for partners served in FY23-24 and FY22-23 (for comparison).

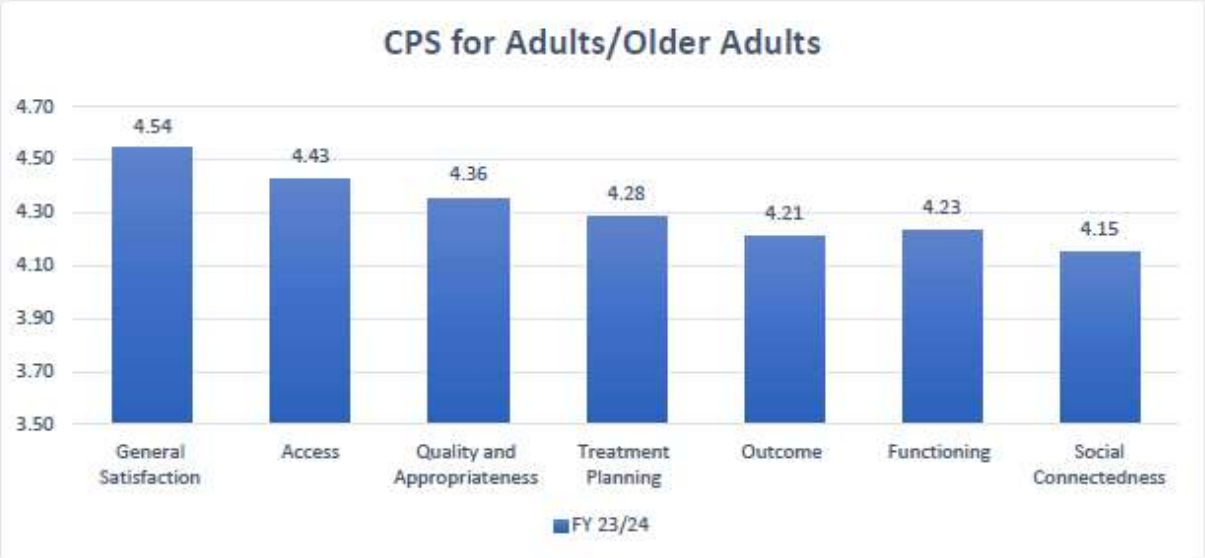
Consumer Perception Survey: Client Satisfaction

Consumer satisfaction was assessed during FY23-24 using the DHCS Consumer Perceptions Survey (CPS). In May of 2024, VCBH administered the survey for a duration of one week, collecting information from those attending services during that time. Forty-six FSP client surveys were identified and summarized.

The CPS assesses client perception of treatment using various domains. Items are scored from 1 (Strongly Disagree) to 5 (Strongly Agree) with higher ratings indicative of higher agreement and satisfaction. In this report, we present the domains of General Satisfaction, Access (to services), Quality, Treatment Planning, Outcome, Functionality (Better Functioning), and Social Connectedness for FSP clients served in FY23-24 and completed the CPS in May 2024.

In general, the CPS domains showcase high satisfaction with VCBH services as shown in Figure A5. The CPS domain mean averages were the lowest for Outcome (4.21), and Social Connectedness (4.15); though given the scale from 1-5, scores in high low 4s still demonstrate a strong degree of satisfaction. The highest rated domain was General Satisfaction (4.54; see Figure A6).

Figure A5. Consumer Perception Survey Results Presented for Adults/Older Adults (N = 46) for FY23-24



Note. Data based on DHCS beneficiary satisfaction data from May 2024

Summary

Are FSP Adult Clients Getting Better?

In addition to the FSP client outcome data presented in the preceding pages, a qualitative description of how an FSP adult client has improved based on a description from their VCBH case manager is presented.

This success story below was provided by a VCBH staff member for an Older Adult Client in the FSP program:

"Prior to coming to the Older Adult Program, T.O. had an extensive history of substance use and homelessness. She was dually diagnosed with Major Depression and alcoholism which cost her career and left her homeless. After coming to the Older Adult Program, she was able to maintain sobriety, treat her clinical depression and get admitted to an RCFE (Residential Care Facility for the Elderly) which provided enough stability for her that she was able to regain a level of functioning that had been lost to her. Working with the Older Adult case manager, she was able to apply for and obtain subsidized housing through the Housing Authority and is working toward independent living.

"I'm looking forward to cooking!" T.O. was excited to be able to have an opportunity to get involved with gardening at the housing unit and hopes to someday re-unite with family members that she had become estranged from, particularly a granddaughter. She was linked to Independent Living Resource Center to furnish the new housing unit.

This was a community effort led by Older Adults that restores the dignity and independence of an older adult client who while needing ongoing support has been able to participate in her own recovery because of resources made available to her."

FSP Youth Clients

The following section examines data for youth partners who received services in an FSP program in FY23-24. A total of 59 youth partners were served in FY23-24. FSP Youth Partners can be served in VCBH's Insights program and in the FSP Youth Program (ATLAS) (established in February 2023) – however, these two programs have recently merged into the Youth & Family FSP Full-Service Program (ATLAS).

The youth FSP programs were developed to address the needs of a population of clients (including juvenile offenders) who are diagnosed with severe emotional disturbances and, potentially, co-occurring substance use disorders, who do not respond well to existing dispositional alternatives and often linger on probation or revolve in and out of custodial facilities and/or out-of-home placements. The program utilizes a multidisciplinary approach to provide intensive treatment and case management services to these youth. Through a collaborative process, coordinated services are offered to the youth and their caregivers which may include comprehensive mental health services, substance use services, peer and parent supports, and other county and community-based support resources. These youth programs have effectively provided Full-Service Partnership level services to diverse, underserved youth populations in all areas of Ventura County.

The data on youth presented here are based on VCBH's electronic health record, not the DCR submissions.

Table A3 displays the demographic information for VCBH's Youth FSP clients. As illustrated in FY23-24 VCBH served a total of 59 unduplicated clients in youth FSP programs.

Table A3. Youth FSP youth client demographic information (N = 59)

Demographics (N = 59 unduplicated Youth FSP Program Clients)		
Category	**N**	**%**
Age Group (n = 59)		
0-15	23	39.0%
16-25	36	61.0%
Sex/Gender (n = 59)		
Female	29	49%
Male	30	51%
Sexual Orientation (n = 29)		
Heterosexual	17	59%
Decline to answer/Not reported	12	41%
Ethnicity (n = 56)		
Hispanic/Latino	38	68%
Non-Hispanic	11	20%
Unknown/Not Reported	7	13%
Primary Language (n = 59)		
Spanish	10	17.0%
English	48	81.0%
American Sign Language	1	2.0%

Are Youth Clients Getting Better?

Currently we do not have enough data to make a determination based on outcome measures for youth FSP clients, and the data on CANS is based on a very small sample of youth partners; thus, it should be interpreted with caution. Future reporting will aim to incorporate additional outcome measures to determine improved functionality in youth based on services provided at VCBH. Qualitatively, program staff in Insights and ATLAS aim to improve the overall quality of life for all partner participants through a variety of services and supports including but not limited to, case management, peer support services, basic needs requests, and housing stability. Through such enhancements Youth FSP programs can provide services leading to a healthier and more resilient youth community.

> One success story highlighted by Insights staff notes –"Despite Insights closing we were able to support one of the final youths in full graduation of the program on the last official day of Insights court. This meant that the youth no longer had as restrictive requirements from probation and the client was able to continue with current mental health and community providers as needed"

Limitations of the Data

Efforts are in place for continual improvements to VCBH's data collection and reporting for FSP programs and clients. However, due to issues with the new EHR system's incompatibility with the state DCR system, the majority of partner data and outcomes could not be utilized and analyzed for the current report. VCBH's EHR and Data Informatics teams are currently working through these issues and receiving technical assistance from DHCS's IT staff with the aim of resolving this issue as soon as possible.

Conclusion and Future Work

Unfortunately, not too many conclusions can be drawn from the data presented in this current report as it focuses predominantly on FY23-24 data that could be accessed and analyzed.

Future work will focus on improved data collection and data entry efforts, including completing a PAF for every partner along with subsequent Quarterly assessments (3Ms) and Key Events (KETs) and working to establish compatibility between the new EHR system and the DCR. VCBH transitioned to a new EHR in FY23-24 and aims to ensure partner data collected are complete and regular for improved reporting of partner outcomes. Moreover, VCBH will continue to ensure that data batched and uploaded into the state's DCR system is complete and accurate. Additionally, VCBH will aim to corroborate partner self-reported information with data collected in the EHR whenever feasible.