

Napa County Mental Health Services Act FY 25-26 Annual Update to Three Year Plan for FY 23-24 to FY 25-26

**Napa County Health and Human Services Agency
Behavioral Health Division**



The 30-day Public Review and Comment Period for the Napa County's Mental Health Services Act (MHSA) FY 25-26 Annual Update to the Three Year Plan for FY 23-24 to FY 25-26 took place from Monday, November 3rd to Wednesday, December 3rd, 2025. The draft plan was posted on Napa County's website, emailed to a broad group of stakeholders and hard copy announcement was posted at the County Clerk's Office. A public hearing of the Napa County Behavioral Health Board took place on Wednesday, December 3rd at 4pm at the Health and Human Services Agency, 2751 Napa Valley Corporate Drive, Building A, 1st Floor, Oak Conference Room, Napa, CA 94559. Public comments were accepted by email at MHSA@countyofnapa.org, at the HHSA Behavioral Health Division Administration Office on the 2nd Floor of Building A, 2751 Napa Valley Corporate Drive in Napa, or during the December 3rd Behavioral Health Board Meeting.



A Tradition of Stewardship
A Commitment to Service

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MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: Napa

Three-Year Plan for FY 23-24 to FY 25-26
 FY 25-26 Annual Update to Three-Year Plan
for FY 23-24 to FY 25-26

Local Behavioral Health Director	Program Lead
Name: Cassandra Eslami, LMFT Telephone Number: (707) 299-2102 E-mail: Cassandra.Eslami@countyofnapa.org	Name: Felix A. Bedolla, Project Manager Telephone Number: (707) 299-1759 E-mail: Felix.Bedolla@countyofnapa.org
Local Behavioral Health Mailing Address: Napa County Behavioral Health Division 2751 Napa Valley Corporate Drive, Bldg. A ANapa, CA 94559	

I hereby certify that I am the official responsible for the administration of county behavioral health services in and for said county/city and that the County has complied with all pertinent regulations and guidelines, laws, and statutes of the Mental Health Services Act (MHSA) in preparing and submitting this MHSA FY 25-26 Annual Update to the Three-Year Program and Expenditure Plan for FY 23-24 to FY 25-26 (hereafter MHSA FY 25-26 Annual Update) including stakeholder participation and non-supplantation requirements.

This MHSA FY 25-26 Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The MHSA FY 25-26 Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate.

The MHSA FY 25-26 Annual Update, attached hereto, was adopted by the Napa County Board of Supervisors on Date TBD.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant. All documents in the attached MHSA FY 25-26 Annual Update are true and correct.

Cassandra Eslami, LMFT
Local Behavioral Health Director (PRINT)

final will be signed
Signature Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION¹

County/City: Napa

Three-Year Plan for FY 23-24 to FY 25-26
 FY 25-26 Annual Update to Three-Year Plan
for FY 23-24 to FY 25-26

Local Behavioral Health Director	County Auditor-Controller/City Financial Officer
Name: Cassandra Eslami, LMFT	Name: Tracy A. Schulze
Telephone: (707) 299-2102	Telephone: (707) 253-4551
Number	Number
E-mail: Cassandra.Eslami@countyofnapa.org	E-mail: Tracy.Schulze@countyofnapa.org
Local Behavioral Health Mailing Address:	Napa County Health and Human Services Agency, Behavioral Health Division 2751 Napa Valley Corporate Drive, Bldg. A Napa, CA 94559

I hereby certify that this Mental Health Service Act (MHSA) FY 25-26 Annual Update to the Three-Year Plan for FY 23-24 to FY 25-26 (hereafter MHSA FY 25-26 Annual Up) is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved MHSA FY 25-26 Annual Update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for other counties in future years. I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

Cassandra Eslami
Local Behavioral Health Director (PRINT)

final will be signed TBD
Signature Date

I hereby certify that for the fiscal year ended **June 30, 2024**, the County has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's financial statements are audited annually by an independent auditor and the most recent audit report is dated **December 30, 2024**, for the fiscal year **ended June 30, 2024**. I further certify that for the fiscal year ended **June 30, 2024**, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund. I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

Tracy A. Schulze
County Auditor Controller (PRINT)

final will be signed TBD
Signature Date

¹ Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (07/22/2013)

EXECUTIVE SUMMARY

This Annual Update describes how Napa County Health and Human Services Agency, Behavioral Health Services, used Mental Health Services Act (MHSA) funding during FY 23–24 and outlines priorities for FY 25–26. It summarizes program activities and expenditures across all MHSA components and highlights where the County is focusing its efforts as it prepares for statewide changes under Proposition 1 and Senate Bill 326.

The update closes out the current three-year MHSA plan and positions Napa County for the transition to the new Behavioral Health Services Act (BHSA), which will take effect in July 2026. The County continues to engage in state and regional planning to ensure a smooth transition and will prepare the BHSA Integrated Plan, with a draft due in March 2026.

System Overview

MHSA continues to fund a broad network of county and community-based programs that serve children, transition-age youth, adults, and older adults. These include Full Service Partnerships (FSPs), outreach and engagement programs, prevention and early intervention services, workforce investments, and infrastructure improvements that strengthen Napa County's behavioral health system.

Community Services and Supports (CSS)

CSS remains the foundation of MHSA programming in Napa County.

Full Service Partnerships (FSPs) provide intensive, field-based support for individuals with the most significant needs. In FY 23–24, the Children's FSP expanded through a new High Fidelity Wraparound program operated by Seneca Family of Agencies for youth involved with Child Welfare Services and Juvenile Probation. Adult and Older Adult FSPs continued to focus on housing stability, diversion from hospitalization or incarceration, and improving quality of life for participants.

Project Access includes System Navigators, Innovations Community Center (ICC), ParentsCAN, and Co-Occurring Support programs that reach individuals who are unserved, underserved, or disconnected from care. The ICC, operated by On The Move, remains a peer-led drop-in center offering art, mindfulness, and social connection activities for adults and older adults. In FY 23–24, ICC hosted more than 1,700 activities and served over 600 participants. System Navigators provided outreach at community events across Napa County, connecting roughly 1,400 residents to information and services.

MHSA funds also continue to support permanent supportive housing for behavioral health clients. During FY 23–24, Napa County allocated \$1.26 million to strengthen the Capitalized Operating Subsidy Reserve (COSR) for Hartle Court Apartments, a 21-unit MHSA-funded supportive housing project for adults living with serious mental illness who are homeless or at risk of homelessness.

Prevention and Early Intervention (PEI)

PEI programs continue to focus on youth wellness, suicide prevention, and outreach to older adults. Local partners include Mentis, VOICES, Up Valley Family Centers, and LGBTQ Connection. Napa also contributes to CalMHSA’s statewide *Take Action* for Mental Health campaign, which promotes public awareness and stigma reduction.

With the transition to the Behavioral Health Services Act, PEI funding will be phased out. Assessments are underway to determine how early intervention programs can be integrated into the new BHSA framework. Counties also await information from the State as to its plans for prevention services since prevention funding was redirected under BHSA to the California Department of Public Health. It is understood that prevention services are a valuable part of the continuum and counties have advocated for funding to be made available locally to help ensure they can be preserved and integrated within the new BHSA framework.

Innovation (INN)

Napa participates in the Learning Health Care Network for Early Psychosis, a statewide Innovation project led by UC Davis and several partner counties. The project builds shared data infrastructure to strengthen early psychosis intervention and evaluation capacity across the state.

Workforce Education and Training (WET)

Building and retaining a strong behavioral health workforce remains a top priority. MHSA WET funding supports recruitment, training, and retention efforts, with an emphasis on developing bilingual and bicultural staff. Napa participates in the Greater Bay Area Regional Partnership, which connects staff to statewide loan repayment and student stipend programs administered by CalMHSA. These opportunities have helped local clinicians reduce student debt and remain in public behavioral health roles.

Capital Facilities and Technological Needs (CF/TN)

During FY 23–24, Napa County completed planning and pre-implementation work for the SmartCare Electronic Health Record (EHR), which went live in October 2025. SmartCare replaces

the previous Credible system and integrates documentation, billing, and reporting for both the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS). The transition is expected to improve billing accuracy, compliance, and coordination of care.

Design and environmental work also advanced for the new Crisis Stabilization Unit (CSU), with groundbreaking in 2025. The new facility will expand local crisis capacity and create a safer, more therapeutic environment for children, youth, and adults in crisis.

Ongoing Challenges

Programs continue to face challenges related to workforce shortages, documentation requirements, transportation barriers, and limited affordable housing. Recruiting and retaining qualified staff, maintaining access for non-English-speaking residents, and balancing administrative workload remain ongoing areas of focus.

Next Steps

As the County prepares to transition to the Behavioral Health Services Act, the Division's priorities for FY 25–26 include:

- Maintaining service continuity during the state transition.
- Improving data and quality systems to meet new reporting standards.
- Completing SmartCare integration and training for county and provider staff.
- Advancing construction of the Behavioral Health Treatment Center, which will expand residential treatment, crisis, and reentry capacity.
- Strengthening coordination and transitions between levels of care.
- Supporting peer services, equitable access, and treatment housing for behavioral health clients.

MENTAL HEALTH SERVICES ACT (MHSA) BACKGROUND

MHSA Principles

The Mental Health Services Act (MHSA) is grounded in the transformation of the public mental health system. Napa County Behavioral Health continues to uphold the following core principles:

- **Community Collaboration** – developing shared visions for services through strong partnerships.
- **Cultural Competence** – ensuring services are responsive and effective for diverse and underserved populations.
- **Individual and Family-Driven Programs** – empowering participants and families to take an active role in recovery.
- **Wellness and Recovery Focus** – promoting resilience, strength, and recovery-oriented approaches.
- **Integrated Service Experiences** – placing mental health services in settings where participants access other critical supports.
- **Outcomes-Based Design** – evaluating effectiveness to ensure accountability and quality improvement.

MHSA Components

MHSA is structured around five (5) components:

1. **Community Services and Supports (CSS)**

CSS funds expand and transform services for children, youth, transition-age youth (TAY), adults, and older adults living with serious mental illness. Services include Full Service Partnerships (FSPs), System Development and Outreach & Engagement, and Housing supports.

2. **Prevention & Early Intervention (PEI)**

PEI focuses on preventing mental illness from becoming severe and disabling. Activities include reducing stigma, increasing early access for underserved communities, and connecting individuals and families to appropriate resources.

3. **Innovation (INN)**

Innovation projects pilot and evaluate new, creative approaches to expand access, improve quality of care and outcomes, and strengthen interagency collaboration.

4. **Workforce Education & Training (WET)**

WET funds support the development of a diverse, well-trained behavioral health workforce. Efforts include training, pipeline development, and promoting the hiring of individuals with lived experience.

5. Capital Facilities & Technology Needs (CF/TN)

CF/TN investments improve service delivery through facility enhancements and technology, such as upgrading electronic health record systems and data reporting capacity.

MHSA History

In November 2004, California voters approved Proposition 63, establishing the Mental Health Services Act. The measure provides ongoing funding through a 1% tax on personal income above \$1 million. These revenues are allocated to counties to expand and transform community mental health services.

The MHSA reflects a commitment to:

- Recovery and resilience as guiding principles,
- Outreach and engagement across all communities, and
- Recognition of individuals living with mental illness as valued members of our community.

In Napa County, MHSA has been a vital resource in building partnerships, reducing disparities, and strengthening services across the lifespan.

MHSA Reporting Requirements

Per Welfare and Institutions Code (WIC) §5847, counties must prepare a Three-Year Program and Expenditure Plan and subsequent Annual Updates that address all MHSA components:

- Community Services and Supports (CSS)
- Prevention and Early Intervention (PEI)
- Innovation (INN)
- Workforce Education & Training (WET)
- Capital Facilities & Technology Needs (CF/TN)

Draft Plans and Annual Updates must be posted for a 30-day public review and comment period, followed by a Mental Health Board public hearing. Final Plans must be adopted by the Napa County Board of Supervisors and submitted to the Department of Health Care Services (DHCS) and the Behavioral Health Services Oversight and Accountability Commission (BHSOAC) within 30 days of adoption.

Highlights, Changes, and Opportunities for FY 25–26

Statewide Behavioral Health Reform

The passage of Proposition 1 and Senate Bill 326 in March 2024 set the stage for California’s transition from the Mental Health Services Act (MHSA) to the Behavioral Health Services Act (BHSA) in July 2026. Napa County Behavioral Health is participating in state and regional planning to understand how the new structure will affect funding, evidence-based practice requirements, and reporting. Over the next year, the Division will prepare the BHSA Integrated Plan, with a draft due in March 2026, and continue to align existing MHSA programs with the new statewide framework.

SmartCare Electronic Health Record

FY 24–25 focused on preparing for the transition to SmartCare, the County’s new electronic health record. SmartCare went live in October 2025, replacing Credible and bringing together documentation, billing, and reporting for both the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS). The system will improve data quality, billing accuracy, and compliance with CalAIM and BH-CONNECT requirements while providing a stronger foundation for quality improvement.

Community Services and Supports (CSS)

CSS remains the cornerstone of MHSA programming in Napa County.

- The Children’s Full Service Partnership (FSP) expanded through a new High Fidelity Wraparound program operated by Seneca Family of Agencies, serving youth involved with Child Welfare Services and Juvenile Probation.
- Adult and Older Adult FSPs continued to focus on housing stability, diversion from hospitalization and incarceration, and recovery-oriented care.
- Project Access—including System Navigators, the Innovations Community Center (ICC), ParentsCAN, and Co-Occurring Support—continued outreach and engagement for individuals who are unserved, underserved, or disconnected from care. ICC hosted more than 1,700 activities and served over 600 participants in FY 23–24.

Prevention and Early Intervention (PEI)

PEI programs continue to focus on youth wellness, suicide prevention, and outreach to older adults, with partners including Mentis, VOICES, Up Valley Family Centers, and LGBTQ Connection. Napa also contributes to CalMHSA’s statewide Take Action for Mental Health campaign. As the County prepares for the transition to the BHSA, dedicated PEI funding will sunset, and the Division is exploring how to sustain early intervention programs that have been vital to community wellness.

Innovation (INN)

Napa County continues its participation in the Learning Health Care Network for Early Psychosis, a statewide Innovation project led by UC Davis and partner counties. The project supports shared data systems and consistent evaluation to improve early identification and intervention for psychosis.

Capital Facilities and Housing Investments

Major capital work advanced during FY 23–24 and FY 24–25.

- The Crisis Stabilization Unit (CSU) design and permitting phases were completed, and groundbreaking occurred in 2025. The new CSU will expand crisis stabilization capacity and create a more therapeutic, trauma-informed environment.
- Napa allocated \$1.26 million to augment the Capitalized Operating Subsidy Reserve (COSR) for Hartle Court Apartments, ensuring the long-term financial stability of the 21-unit permanent supportive housing project for adults with serious mental illness.

Behavioral Health Treatment Center (BHTC)

Planning continues for the Behavioral Health Treatment Center, which will expand local residential treatment, crisis, and reentry capacity. The project represents a major opportunity to reduce out-of-county placements and strengthen coordination across levels of care.

Workforce and Peer Development

Napa County continues to prioritize workforce stability and peer integration. Through the CalMHSA Workforce Education and Training (WET) partnership, staff and students accessed loan repayment and stipend opportunities that help retain qualified clinicians. The County also expanded its Certified Medi-Cal Peer Support Specialist (CMPSS) workforce and increased the role of peers across programs.

Opportunities Ahead

Looking forward, FY 25–26 will focus on:

- Preparing for full BHSA implementation and completing the Integrated Plan.
- Completing SmartCare implementation and using data to drive equity and quality improvement.
- Advancing construction of the Behavioral Health Treatment Center.
- Sustaining critical early intervention programs as PEI funding sunsets.
- Improving transitions between levels of care and building a more coordinated crisis response system.
- Continuing to support a skilled, diverse, and peer-inclusive workforce that reflects the community we serve.

Overview of Napa County

Napa County is home to approximately 138,795 residents (ACS 2021), and while globally known for its vineyards and natural beauty, its communities face persistent inequities in health, housing, and opportunity. The county is geographically and culturally diverse, with a high concentration of Latino/a/x residents (34.7%), a growing population of older adults (24% age 65+), and substantial rural and urban divides. Napa County includes urban centers like Napa and American Canyon, as well as agricultural and remote regions such as Angwin and Calistoga.



Informed by the 2023 Community Health Needs Assessment (CHNA) and the 2024–2027 Community Health Improvement Plan (CHIP), five priority areas guide health equity efforts: housing, behavioral health, access to care, racial equity and LGBTQ+ inclusion, and economic stability. High-need areas defined by lower income, education levels, and life expectancy are home to approximately 50% of Napa County residents. These tracts are more likely to house families with children, monolingual Spanish speakers, and individuals with limited access to care.

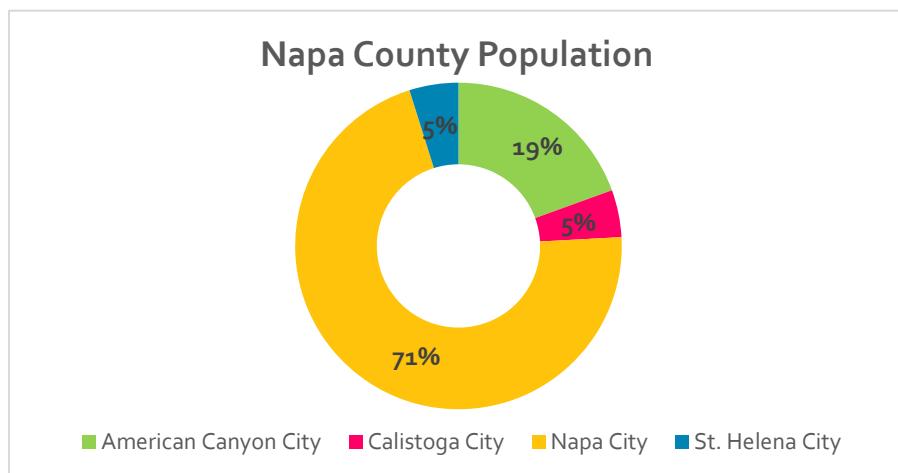
Housing insecurity continues to impact health outcomes. Nearly 25% of renter households spend more than 50% of their income on rent, and low-wage workers across industries, including education, agriculture, and hospitality, often cannot afford to live where they work. The median income in high-need tracts is \$84,690, compared to over \$117,000 in higher-resourced areas.

Behavioral health needs, particularly access to culturally responsive and bilingual services, remain among the most pressing challenges. The county's behavioral health system faces a shortage of providers, especially those able to serve youth, LGBTQ+ individuals, and the Spanish-speaking population.

The County's HHSA Strategic Plan (2024–2026) emphasizes culturally appropriate outreach, co-located services, and reducing structural barriers through partnerships and community-based solutions. These efforts are designed to address historic and current inequities, increase public trust, and ensure services meet the needs of residents across Napa's diverse communities.

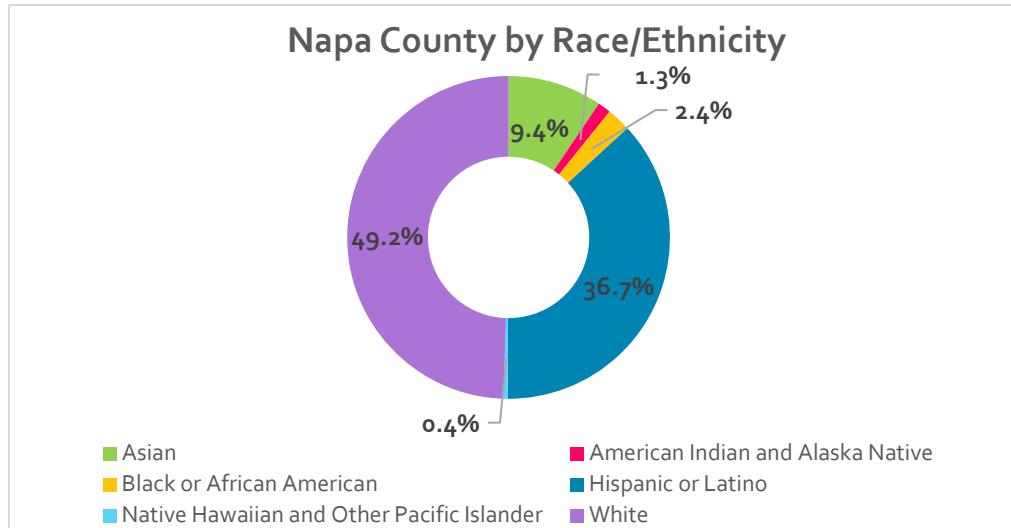
Napa County Demographics

The graph below illustrates the population distribution within Napa County by city. Napa City is the largest, comprising over 70% of the county's residents. American Canyon is the second most populous city, with approximately 19% of residents. Both Calistoga and St. Helena each account for about 5% of the county's population.¹

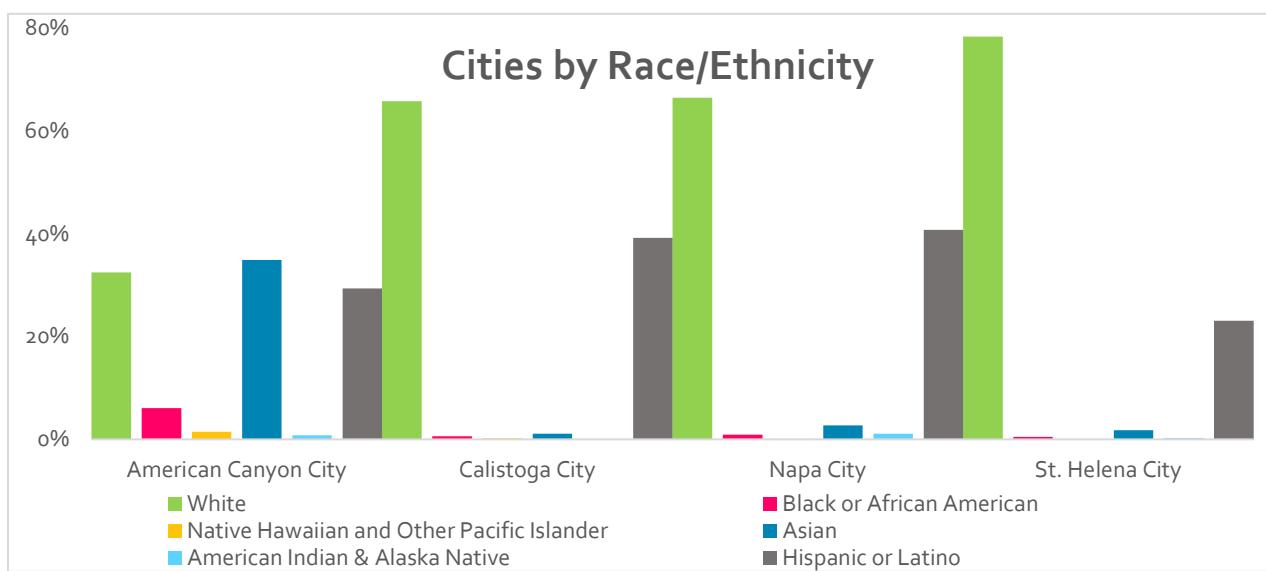


¹ [US Census Bureau](#)

The two largest racial/ethnic groups in Napa County are White and Hispanic/Latino, comprising approximately 49% and 36% of the population, respectively. Asian residents form the third largest group, accounting for about 9%. Just over 2% identify as Black or African American, around 1% as American Indian or Alaska Native, and less than 1% as Native Hawaiian or other Pacific Islander. Additionally, approximately 3.6% of residents identify as two or more races. Spanish is the only threshold language spoken in the county; however, over 33% of residents speak a language other than English at home.²



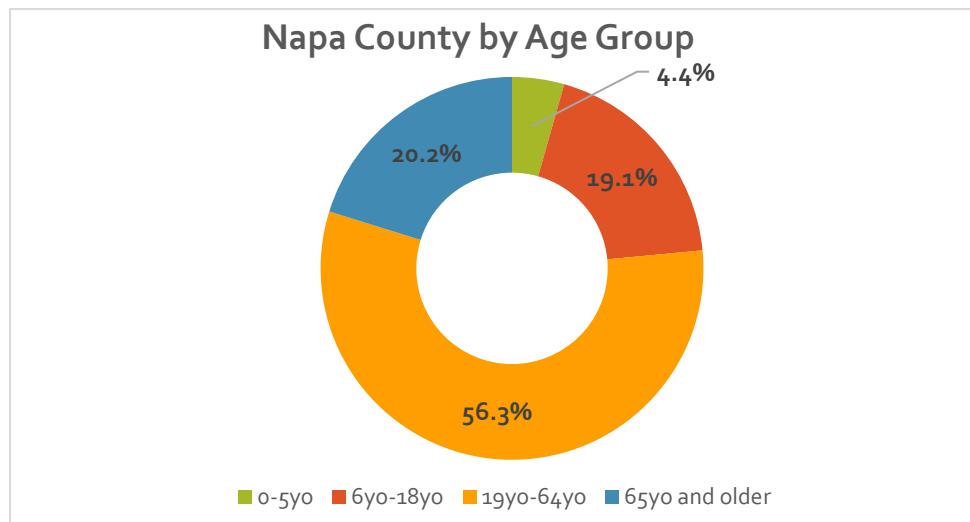
The following graph shows Napa County's population by city and race/ethnicity. American Canyon continues to be the most diverse city in the county, with nearly 35% of residents identifying as Asian and 29% as Hispanic/Latino. In contrast, St. Helena remains the least diverse, with over 78% of residents identifying as White, just over 1% as Asian, and 23% as Hispanic/Latino.³



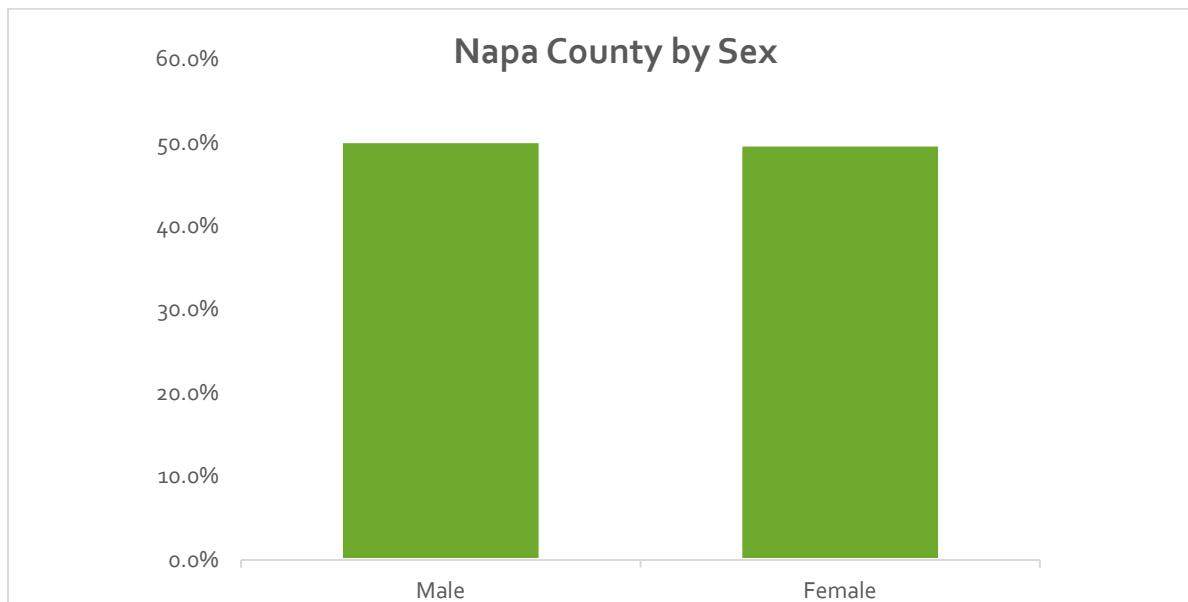
² [US Census Bureau](#)

³ [US Census Bureau](#)

The largest age group in Napa County includes adults between the ages of 19 to 64 years old, accounting for over 56% of the population. The second largest age group is those 65 years and older, while the smallest is the age group 0 to 5 years old.⁴



Just over 50% of Napa County residents identify as male, representing a slight majority of the population. Conversely, females comprise just under 50%, reflecting a nearly balanced gender distribution across the county.⁵



⁴ [US Census Bureau](#)

⁵ [US Census Bureau](#)

Mental Health Needs of Unserved/Underserved Residents

Since adoption of the 2023–2026 MHSA Three-Year Plan, unmet behavioral health needs remain high in Napa County. While no new county-level prevalence surveys have been released since CHIS 2020 or CHKS 2022, multiple recent local planning efforts confirm ongoing gaps and disparities.

Youth mental health: The most current CHKS (2022–2023) for high-school students continues to show elevated reports of chronic sadness/depression and suicidal ideation, reinforced by the 2023 Community Health Assessment/Needs Assessment (CHA/CHNA), which prioritized Behavioral Health.

Older adults: Napa County has a comparatively larger share of older residents; local plans flag the need to reduce isolation and improve access for older adults. (Statewide data show elevated suicide risk among men 85+, underscoring prevention needs that are relevant locally.)

Housing instability and homelessness: A 2024–2025 Housing Needs Assessment estimates a ~20-year deficit of ~9,700 homes, with ~65% of the shortfall in affordable units, conditions linked in local assessments to stress and barriers to care.

Access and equity gaps: The 2023 CHNA documents long waitlists, shortages of bilingual/bicultural providers, and barriers for Latine, BBIPOC, LGBTQIA+, and rural residents. The HHSA 2024–2026 Strategic Plan commits to reducing language/cultural barriers and expanding integrated, place-based services.

Substance use: The 2024–2027 Community Health Improvement Plan (CHIP) prioritizes opioid-related prevention and treatment, with county actions funded through 2027.

Ongoing disaster impacts: Wildfires and related emergencies continue to affect residents' well-being and service access, reinforcing the need for responsive, trauma-informed supports.

Community Planning Process linkage: These needs mirror feedback from Napa's CPP activities (public comment/hearing and stakeholder engagement summarized in this Update) and continue to guide FY 25–26 priorities.

Implications for MHSA (FY 25–26)

- **Youth mental health:** Partner with schools as they implement Children and Youth Behavioral Health Initiative (CYBHI) and the new fee schedule; strengthen efforts that link children and families to SMHS and SUD services.
- **Older adults:** Continue early-identification activities, with linkage to treatment and short-term intervention.

- **Housing & homelessness:** Deepen alignment with the Homeless Response System and MCP partnerships to expand access to CalAIM housing supports (navigation, tenancy services), coordinated with local housing initiatives.
- **Access & equity:** Increase bilingual/bicultural staffing, expand rural access points, and strengthen language-access supports, consistent with HHSA's strategic direction.
- **Substance use (OUD focus):** Continue prevention efforts, MAT linkages, and harm-reduction partnerships through 2027, aligned with county priorities.

Assessment of the County's Capacity to Implement Mental Health Programs and Services

In FY 23-24, Napa County Health and Human Services Agency Behavioral Health conducted a comprehensive MHSA Capacity Assessment Survey of contracted community-based providers. The full results were included as Appendix 1 of the FY 24-25 Annual Update and established a baseline of provider strengths, workforce diversity, bilingual proficiency, and barriers to implementation.

This FY 25-26 Annual Update builds on that baseline, providing updated information on workforce demographics, language access resources, system quality improvement efforts, and infrastructure enhancements that reflect Napa's current capacity to implement MHSA programs and services.

Workforce and Equity

Recruitment and retention remain ongoing challenges, but Napa has built supports such as flexible scheduling, recognition programs, and secondary trauma resources. Workforce pipelines are being strengthened through paid internship stipends, licensure support, and internal promotion pathways, with an emphasis on recruiting and retaining bilingual and bicultural staff. As of 2024, 55% of HHSA staff identify as Hispanic/Latino compared to 35% countywide, while 29% identify as White compared to 50% countywide. This reflects strong Latinx representation overall, though leadership roles remain less diverse. Asian, Black/African American, and multiracial representation is proportionate to county demographics, while Native Hawaiian/Pacific Islander and American Indian representation remain limited.

Strengths and Limitations

Napa's MHSA providers bring notable strengths, including deep community connections and bilingual/bicultural staff who reflect the populations they serve. These assets have supported strong engagement with Latinx communities in particular and have allowed providers to build trust and reduce stigma. Limitations continue to include vacancies in key bilingual positions,

underrepresentation of African American and Asian staff, and limited language diversity beyond English and Spanish.

Bilingual Proficiency and Language Access

Spanish is Napa County's only non-English threshold language. Napa BH employs certified bilingual Spanish staff to provide interpretation and translation during both clinical and non-clinical interactions. Additional capacity is supported through a contract with Language Line Services, Inc., which offers:

- 24/7 telephone interpretation in multiple languages.
- Video interpretation.
- In-person interpretation for appointments, treatment planning, and care coordination.
- Translation of written materials, including beneficiary handbooks.
- All services are provided free of charge to clients. For non-threshold languages, Policy 06-6020 guarantees interpretation in any language through the Access Line, available 24/7, with auxiliary aids such as TTY services and large-print materials. These resources ensure all MHSA clients, regardless of language, can fully access and engage in care.

Barriers and Strategies

Providers participating in the FY 23-24 MHSA Capacity Assessment Survey identified several persistent barriers to implementing MHSA programs and services. These included:

- **Transportation challenges** that make it difficult for clients to access services.
- **Limited referral networks and waitlists**, which reduce timely access to care.
- **Administrative burdens**, including increasingly complex grant and reporting requirements, which providers said take time and resources away from service delivery.

In response, providers and the County are addressing these barriers through culturally responsive partnerships with community-based organizations, warm handoffs between programs, expansion of in-house services, pursuit of grant funding, and targeted recruitment of bilingual/bicultural staff.

System Quality and Readiness

Napa HHSA Behavioral Health has addressed External Quality Review Organization (EQRO) recommendations by improving discharge protocols, telehealth consents, and urgent referral workflows. The Quality Assurance Performance Improvement (QAPI) Workplan 2025 tracks measurable improvement goals: reducing no-shows, improving medication adherence,

expanding peer services, and increasing Latinx penetration rates. Participation in the BH-CONNECT Incentive Program positions Napa to align with National Committee for Quality Assurance (NCQA) quality standards and access incentive funding for system improvements.

Technology and Telehealth

Updated telehealth consent protocols and annual trainings support safe and equitable remote care. The upcoming SmartCare Electronic Health Record (EHR) go-live in October 2025 will expand data-sharing, reporting, and compliance, enhancing capacity for oversight and coordination.

Together, these activities demonstrate Napa's current ability to deliver MHSA programs and services. They also align with the HHSA 2024–2026 Strategic Plan, which emphasizes equity, access, integration, and workforce development.

Efforts to Increase Access and Capacity to Implement Mental Health Programs and Services

Napa BH is actively building additional access and capacity to address gaps identified through the MHSA survey, stakeholder feedback, and performance monitoring. These efforts respond directly to barriers such as staff vacancies, limited bilingual licensed providers, rural access, transportation challenges, and administrative burdens.

Workforce Development

Participation in the Greater Bay Area Regional Partnership has expanded access to loan repayment and stipend programs. In Napa, the county funds Social Work and MFT interns with \$10,000 stipends and recruits them into permanent roles, helping to grow the pipeline of licensed professionals. Additionally, targeted recruitment efforts emphasize hiring bilingual and bicultural staff to address workforce shortages and ensure services reflect the cultural and linguistic needs of the community.

Service Expansion

Continued co-located services at the Library, Jail and Probation, and the Innovations Community Center, along with the addition of new satellite offices in Calistoga, have expanded access to behavioral health services in underserved areas. The launch of the Mobile Response Team (MRT) in December 2023 has further strengthened community-based care by providing crisis response directly in the field, reducing the reliance on law enforcement and hospital emergency departments.

Community Outreach and Engagement

System Navigators participate in community events year-round to support engagement and

facilitate linkages to services. Bilingual outreach campaigns, such as those conducted during Mental Health Month and suicide prevention initiatives, play a vital role in reducing stigma and raising awareness. Additionally, the Behavioral Health Outreach Committee meets monthly to coordinate culturally responsive outreach strategies, ensuring efforts are aligned and effective.

Equity and Inclusion

Workforce demographics indicate strong Latinx representation overall, while also highlighting the need to enhance diversity within leadership roles. Interpreter and translation services, including Spanish threshold language support and Language Line for other languages, ensure comprehensive language access for all clients. The REIDB committee, along with the use of a policy review tool, promotes culturally inclusive program development to better serve diverse communities.

Housing and Homelessness

The 2025 Point-in-Time Count documented a 10% decrease in overall homelessness, along with a significant reduction in first-time homelessness. MHSA-funded treatment housing and capacity-building grants play a critical role in sustaining this progress and preventing homelessness among individuals with serious behavioral health needs.

Collaboration and Systems Integration

Napa County is advancing CalAIM initiatives, including Enhanced Care Management and the Justice-Involved initiative, through formal agreements with Managed Care Plans (MCPs).

Partnerships with Queen of the Valley Hospital, facilitated by Access Care Navigators, enhance follow-up care after emergency department and psychiatric hospital visits. Moreover, local quality committees such as Behavioral Health Quality Improvement Committee (BHQIC) and Utilization Review Steering Committee (URSC) play a key role in continuously monitoring access, timeliness, and equity within the system.

These efforts go beyond maintaining current capacity; they represent deliberate actions to expand services, reduce disparities, and ensure that MHSA-funded programs are responsive to community needs. They also complement the HHSA 2024–2026 Strategic Plan, ensuring MHSA investments are coordinated with broader county priorities.

Community Planning Process (CPP)

Napa County HHSA Behavioral Health's Community Program Planning (CPP) process ensures that local voices, diverse perspectives, and lived experiences meaningfully shape the Mental Health Services Act planning, implementation, and evaluation efforts. The CPP process emphasizes transparency, equity, and accountability through structured stakeholder engagement, regular public meetings, and ongoing collaboration with community partners.

Roles and Facilitation

The Behavioral Health Division's MHSA Project Manager leads all CPP activities, including scheduling, facilitation, documentation, and synthesis of stakeholder input. The MHSA Staff Services Analysts provide coordination, note-taking, and logistical support to ensure inclusive and accessible participation across programs and populations.

The Mental Health Stakeholder Advisory Committee (SAC) serves as the standing body for ongoing MHSA input and review. Its purpose, representation, and member expectations—two-way communication, agenda participation, voting, and dissemination of information are described in the SAC Roles & Responsibilities (see Appendix 2). This structure fulfills statutory requirements for meaningful engagement of consumers, family members, providers, and community partners throughout planning, implementation, and evaluation.

SAC Representation

SAC members represent a cross-section of the community, including consumers and family members, community-based organizations, behavioral health and substance use providers, law enforcement, school personnel, community health providers, Behavioral Health Board members, and representatives from unserved or underserved groups such as Latinx, LGBTQ+, older adults, and representatives from Up-Valley and American Canyon. SAC participation is designed to ensure diverse geographic, linguistic, and cultural perspectives are included in MHSA decision-making.

Methods Used to Elicit Input (FY 23–24 - FY 24–25)

The Division continues to build upon and draw from prior CPP findings to maintain continuity in community voice. Each year's process reviews earlier themes, demographic participation, and system-capacity findings to assess progress and refine strategies. This iterative approach ensures that equity, access, and workforce-capacity needs identified through earlier engagement remain central to MHSA and now BHSA planning.

CPP engagement activities are designed to reach a wide range of stakeholders and to close feedback loops through summary reports, SAC updates, and transparent tracking of priorities over time. These practices reinforce the Division's commitment to sustained community participation, equity, and accountability.

Regular SAC Meetings and CPP Engagement.

The SAC meets regularly (virtually and open to the public) to review MHSA programs, receive updates, and provide ongoing input that informs both CPP and BHSA planning.

Discussion summaries and stakeholder input are outlined below:

- **December 2023:** Presentations from Up Valley Family Resource Center (Senior Wellness Program) and Molly's Angels (Older Adult PEI Program) highlighted the importance of reducing isolation, addressing transportation barriers, and expanding outreach to bilingual and bicultural seniors. SAC members emphasized coordination among senior-serving agencies, better outreach in Up-Valley and rural communities, and culturally responsive care.
- **February 2024:** Mentis presented *Healthy Minds, Healthy Aging*, focusing on case management and therapy for older adults and caregivers. Input centered on the need for stronger referral pathways, caregiver support, and sustainability of bilingual outreach staff.
- **March 2024:** LGBTQ Connection and VOICES shared *Rise for Napa* and the *Guaranteed Income Project for Foster Youth*. Members discussed how programs supporting LGBTQ+ and transitional-age youth could align with Prevention and Early Intervention goals by fostering inclusion, peer connection, and early access to affirming behavioral health supports.
- **April 2024:** Napa Valley Education Foundation presented on school-based wellness centers and social-emotional learning programs. Discussion focused on improving linkages between schools, community providers, and County services to enhance early identification and reduce crisis escalations.
- **May 2024:** Mentis presented *Building a Safety Net for Youth Mental Health Wellness* and the *Bridges Community Treatment Program*. SAC members provided input on youth engagement, transition supports, and reducing duplication among community partners.

Ongoing Communication and Inclusive Engagement.

Outside of SAC meetings, Division staff connected with community partners, peer networks, and County committees to share MHSA updates and gather informal input on program needs and system gaps. Staff encouraged feedback from individuals with lived experience, cultural brokers, and bilingual community representatives, reinforcing the goal of equity-driven and person-centered planning.

Countywide Assessments Informing CPP

The CPP process intentionally builds upon and aligns with other countywide planning and assessment efforts that have engaged thousands of residents through focus groups, surveys, and community forums. Drawing on these complementary inputs allows MHSA planning to

reflect a shared understanding of local needs and to coordinate strategies across housing, health, and behavioral health systems.

Local inputs informing the CPP include:

- **HHSA Strategic Plan (2024–2026):** Establishes agencywide goals to reduce health inequities, expand integrated and place-based services, and improve access through language and cultural responsiveness. CPP priorities related to access, workforce, and equity mirror these agency goals.
- **Community Health Needs Assessment (CHNA, 2023) and Community Health Improvement Plan (CHIP):** Identified five shared priorities—housing, behavioral health, access to care, racial equity and LGBTQ inclusion, and economic stability. CPP discussions echoed these themes, particularly the importance of behavioral health access and housing stability.
- **Older Adult Needs Assessment (2022–2024):** With input from more than 1,500 residents, identified key needs around transportation, caregiving, social connection, and equitable access. Findings informed CPP discussions on senior outreach and prevention programs.
- **Farmworker Housing and Impacts Assessment (2023):** Highlighted housing insecurity, long commutes, and access barriers among essential workers and their families. CPP participants emphasized the need for more mobile, bilingual, and field-based services to reach these populations.
- **Housing Needs Assessment (2022):** Provided data on the shortage of affordable and supportive housing, reinforcing the CPP focus on housing partnerships, Behavioral Health Bridge Housing, and expansion of supportive housing options.
- **Countywide Transportation Study (2022):** Documented mobility challenges for low-income residents, older adults, and rural populations, underscoring the importance of co-locating behavioral health services near transit routes and community hubs.

Together, these assessments provide a robust foundation for MHSA planning, ensuring that County behavioral health priorities remain responsive, data-informed, and aligned with broader community strategies.

Complementary Engagement Efforts Leveraged for MHSA/BHSA CPP

In addition to regular CPP engagement, Napa County HHSA Behavioral Health conducted extensive outreach and stakeholder sessions tied to the 2024 Behavioral Health Continuum Infrastructure Program (BHCIP) planning process. These efforts, though initiated under separate funding and facility planning mandates, significantly enriched the CPP by generating community-informed data on system gaps, capacity needs, and cross-sector collaboration.

Behavioral Health Treatment Campus (BHTC) Engagement (2023–2024):

To inform the development of the proposed Behavioral Health Treatment Campus, the Division hosted multiple engagement sessions with law enforcement, courts, probation, community-based organizations, people with lived experience, substance use treatment providers, and SAC members. Meetings included facility site visits, design consultations, focus groups, and presentations to the Behavioral Health Board.

Key themes raised included:

- Persistent gaps in withdrawal management and residential SUD treatment, especially for individuals stepping down from jail or hospital settings.
- The need for a designated Mental Health Rehabilitation Center (MHRC) to reduce out-of-county placements and improve treatment continuity.
- Broad support for establishing a sobering center to reduce unnecessary emergency-department utilization and support diversion from the criminal-justice system.
- Calls for stronger linkages between behavioral health, justice, and housing systems, including coordination with the Public Defender, Probation, and Sheriff's Office for early identification and warm handoffs.
- Emphasis on equitable access through bilingual navigation, peer support, and transportation assistance to ensure the campus is accessible to all communities.

Stakeholder Involvement and Feedback Loops

The SAC serves as the primary venue for cross-sector input and public dissemination of MHSA and BHSA information. Meetings are open to the public and documented through agendas and minutes that capture feedback, program updates, and next steps.

To maintain transparency and accountability, Division staff routinely report back on how stakeholder feedback is incorporated into planning and contracting decisions. Beyond the SAC, the Division gathers input through the Behavioral Health Board, the Cultural Competence Committee, Quality Improvement and Utilization Review committees, contractor forums, and County-wide staff meetings, ensuring broad and equitable participation across the system.

Local Review Process (Annual Update) — To Be Completed at Adoption

30-Day Public Comment Period

The draft FY 25–26 MHSA Annual Update was circulated for public review from October 31, 2025, through December 3, 2025. Copies were distributed through the SAC listserv and MHSA mailing list, shared with community partners and the Behavioral Health Board, posted on the County website at www.napacounty.gov, and available in hard copy at Health and Human Services Agency, 2751 Napa Valley Corporate Drive, Building A, 2nd Floor, Napa, CA 94559. Alternative formats and language access will be provided upon request.

Public Hearing

Following the comment period, the Behavioral Health Board will conduct a public hearing on December 3rd, 2025, at Health and Human Services Agency, 2751 Napa Valley Corporate Drive, Building A, 1st Floor, Oak Conference Room, Napa, CA 94559. A summary of comments, staff responses, and any revisions will appear in Appendix 4: *Public Comments & Responses*.

Public Comment Summary

During the 30-day public comment period, Napa County received written public comment from a community-based organization serving older adults. The comment expressed strong support for the County's efforts to prioritize equity, access, and early intervention, and affirmed the importance of older adults as a priority population. Key themes included the ongoing impacts of social isolation, transportation barriers, service navigation challenges, and the need for bilingual and culturally responsive outreach. The commenter highlighted the role of transportation and community-based outreach in preventing missed appointments, reducing crisis risk, and improving continuity of care for seniors. The comment also emphasized the importance of sustaining older-adult prevention and early-intervention supports as the County transitions from MHSA to the Behavioral Health Services Act. The full public comment and County response are included in Appendix 4.

How FY 2023–2024 and FY 2024–2025 Input Shaped Planning

- **Equity & Access:** CPP discussions and demographic analysis guided targeted outreach to older adults, Latinx residents, and LGBTQ+ youth. Data collected during the CPP confirmed meaningful participation from these groups and identified areas for deeper engagement in future MHSA cycles.
- **Priority Alignment:** CPP priorities were mapped to HHSA's Strategic Plan goals, reducing language and cultural barriers, expanding integrated care, and strengthening linkages between behavioral health, housing, and recovery systems.
- **Program Refinements:** Stakeholder feedback reinforced the need for continued investment in school-based wellness supports, senior outreach and prevention, and youth engagement programs. These priorities are being tracked through FY 2024–2025 performance outcomes and will continue to inform MHSA and BHSA planning cycles.
- **System Learning and Accountability:** Each CPP cycle informs the next through structured follow-up at SAC meetings, ensuring that stakeholder input directly influences program design, RFP priorities, and resource allocation decisions across MHSA initiatives.

Community Services and Supports (CSS)

Component Overview

The Behavioral Health Division's Community Services and Supports (CSS) component delivers a coordinated array of programs that address the diverse behavioral health needs of Napa County residents. Services include Full Service Partnership (FSP) wraparound care, mobile crisis and response through the Mobile Response Team (MRT), peer-operated recovery supports, system navigation, and targeted outreach and engagement.

As the cornerstone of the Mental Health Services Act (MHSA), CSS is designed to reduce the long-term impacts of untreated mental illness and serious emotional disturbances by engaging unserved, underserved, and inappropriately served populations across the lifespan.

CSS funding supports services for children, youth, transition-age youth (TAY), adults, and older adults living with serious mental illness or serious emotional disorders. All programs are guided by MHSA's core principles of:

- Community Collaboration
- Cultural Competence
- Client and Family-Driven Approaches
- Wellness, Recovery, and Resilience Focus
- Integrated Service Experiences

Together, these principles ensure that Napa County's services remain recovery-oriented, person-centered, and culturally responsive.

Full Service Partnerships (FSPs)

Full-Service Partnership (FSP) programs are in-house initiatives designed to provide a comprehensive, "whatever it takes" wraparound approach to support consumers. These programs offer a wide array of services and supports that extend beyond the traditional mental health model. Services may include assistance with attending meetings, meeting daily living needs, covering healthcare expenses, and providing respite care when necessary.

The FSP programs are organized into five units: Children's FSP (CFSP), Transitional Age Youth FSP (TAY), Adult FSP (AFSP), Adult Treatment Team (ATT), and Older Adult FSP (OA FSP). In FY 23-24, the Behavioral Health Division plan expanded the Children's FSP by introducing a High Fidelity Wraparound model to specifically serve youth involved in Child Welfare and Juvenile Probation. Building on this foundation, each FSP unit tailors its services to meet the unique needs of the populations they serve. The following sections provide an overview of each unit.

Children's Full Service Partnership (CFSP)

Program Description

The CFSP program provides a holistic approach that includes assessment, plan development, individual and family therapy, behavioral interventions, crisis stabilization, case management and ongoing referrals. Children and youth who we serve have a range of presenting problems including severe anxiety, depression, trauma, substance use, and behavioral problems that impacted important life domains. Some of our children and youth needed academic support through a 504 or IEP plan, an evaluation by a Child's Psychiatrist to address the benefit of medication services, and/or coordination of care with Probation Offices or Child Welfare Social Workers. The CFSP worked closely with both families and providers to help families address their mental health needs and successfully graduate from treatment.

Target Population

The CFSP serves those who are underserved and low income and whose mental health symptoms severely impact important domains in their life. Domains include family and peer relationships, academic performance, at risk of not meeting developmental milestones, psychiatric hospitalization, incarceration, and/or removal from the home. The frequency and intensity of services is 1-3 contacts per week. The Children's Full-Service Partnership (CFSP) Program provided wraparound services to children and youth between the ages of 0-15.

Key Activities and Services

A foundational principle of the CFSP program is empowering families with "voice and choice" in their treatment. The Child Family Team (CFT) meetings serve as a collaborative forum where children, youth, families, their natural support networks, and providers come together to recognize strengths, identify needs, and develop comprehensive, family-centered plans.

In a significant milestone for the CFSP program, a dedicated CFT facilitator has been appointed to enhance the coordination and facilitation of these meetings. The selection criteria emphasized bilingualism, bicultural competence, and a combination of professional and lived experience, ensuring a well-rounded and effective approach to support. With this addition, families engaged with the CFSP Team now have access to a multidisciplinary group comprising a therapist/case manager, parent partner, behaviorist, and CFT coordinator, further strengthening the support network.

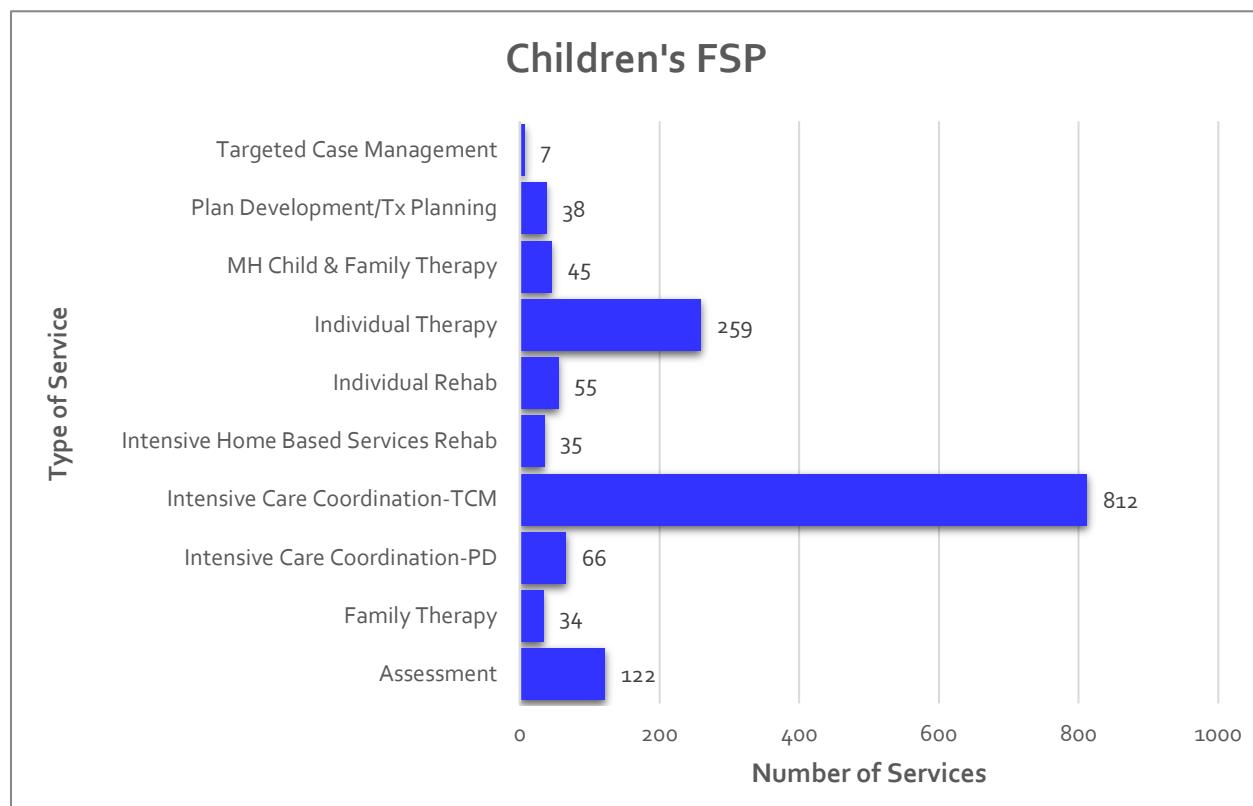
Prevention and early intervention remain core values of the CFSP program. Staff have been trained in and familiarized with the Five Protective Factors Framework, and ongoing consultations are tailored to meet the specific needs of children aged 0-5. Additionally, the community resource library for younger children continues to grow, enhancing available support options.

To create a more welcoming and developmentally appropriate environment, the CFSP Team has undertaken a remodeling initiative for treatment rooms serving this population. Two fully

equipped treatment rooms, the Sensory Room and the Active Playroom, have been designated to support younger children. These spaces have been furnished with age-appropriate furniture, toys, books, and clinical interventions, ensuring families feel comfortable and staff have the necessary tools to provide effective clinical care.

Client Demographics and Service Volumes

For FY23-24, Napa County Behavioral Health provided services to a total of 39 children enrolled in the CFSP program. The following graphs provide an overview of the number of services delivered, as well as the demographic characteristics of the children served.

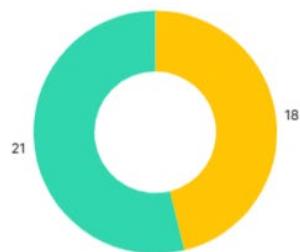


Demographics

Total Clients Served:

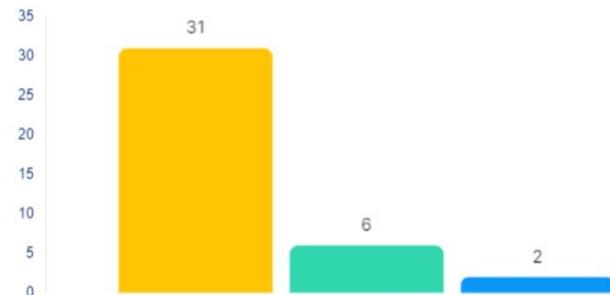
39

Age



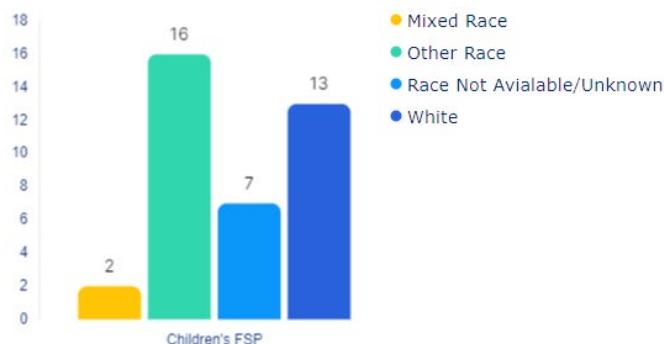
● Children/Youth (0-15) ● Transition Age Youth (16-25)

Language



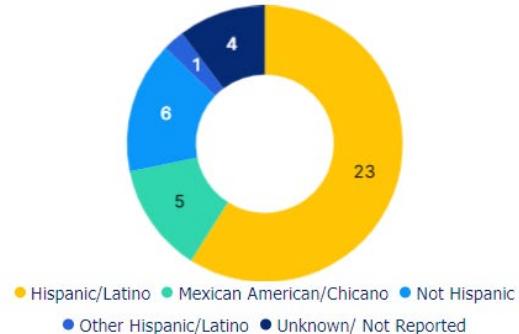
● English ● Spanish ● Unknown/Not Reported

Race



Children's FSP

Ethnicity

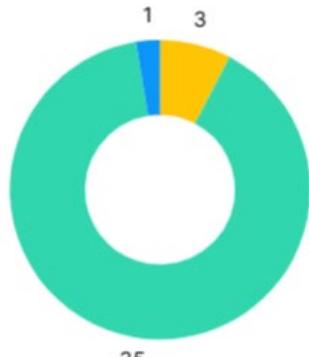


Disability



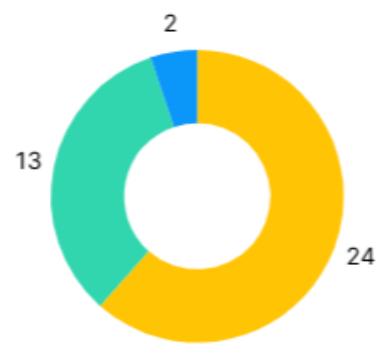
● Other ● No Disability

Sexual Orientation



● Heterosexual/Straight ● Unknown/Declined to State
● Unsure/Questioning/Don't Know

Gender



● Female ● Male ● Transgender

Estimated individuals served and cost per client:

Children's FSP

Age	FY 23-24 Individuals Served	FY 24-25 Projected Individuals Served	FY 25-26 Projected Individuals Served
0-15 Children/Youth	39	53	50
16-25 TAY	0	0	0
26-59 Adult	0	0	0
60+ Older Adult	0	0	0
Total	39	53	50
Funding	\$559,017	\$555,286	\$524,961
Cost per client	\$14,333.77	\$10,477.09	\$10,499.22

Outcome Highlights

The Children's Full Service Partnership (CFSP) program serves underserved, at-risk children with serious emotional disturbances. Eligible children must exhibit significant challenges in at least two key areas—school, home, community, or peer relationships—or be at risk for hospitalization, incarceration, suicide, homicide, removal from the home, or long-term impairment without treatment.

The CFSP provides intensive, individualized, and strength-based services rooted in the belief that children and families thrive when care is both culturally responsive and connected to meaningful community support. The program's use of flexible funding has been instrumental in helping families address essential needs such as food and stable housing. By alleviating these stressors, caregivers are better able to be physically and emotionally present with their children.

Flex funds have expanded opportunities for children to participate in extracurricular and recreational activities such as sports, art classes, and camps. These experiences build social-emotional skills, reduce isolation, foster mentoring relationships, and help youth feel more integrated into their communities.

The CFSP team operates with a trauma-informed, developmentally focused, and culturally responsive lens. This approach builds trust with families and has proven effective in reducing risks associated with academic failure, psychiatric hospitalization, disrupted attachment, and juvenile justice involvement.

In keeping with its commitment to “whatever it takes,” CFSP staff provide highly flexible services to meet families’ needs. This includes outreach in schools and communities, extended service hours, frequent client contact, and bilingual care. Through these efforts, the program ensures

that families receive support when and where they need it, ultimately strengthening resilience and improving long-term outcomes.

Challenges and Adaptations

The Children's Full-Service Partnership (CFSP) Program continues to face challenges in addressing the complex needs of children and families, including co-occurring conditions, academic struggles, and involvement with multiple systems of care. Recruitment of a full-time bilingual, bicultural clinician remains a priority to further reduce cultural and linguistic disparities. Coordinating care across diverse systems, including schools, probation, child welfare, and hospitals, also presents ongoing logistical challenges.

To address these barriers, CFSP has implemented several adaptations. The addition of a CFT facilitator has strengthened family engagement and cross-system coordination. Staff have expanded their expertise through specialized training in suicide prevention, trauma, eating disorders, and racial equity. Treatment spaces have been remodeled to better meet the developmental needs of young children. Flex funds continue to provide families with both stability and opportunities for growth. Guided by its "whatever it takes" philosophy, CFSP offers services in schools, homes, and community settings, at flexible hours, in families' preferred languages, and with the frequency needed to ensure meaningful progress.

Children's FSP Expansion - Seneca High Fidelity Wraparound

Program Description

The Seneca High Fidelity Wraparound (HiFi Wrap) program was launched in FY 23–24 to expand Napa County's Children's Full Service Partnership (CFSP) and serve youth involved in Child Welfare Services and Juvenile Probation. Operated by Seneca Family of Agencies, the program provides intensive, team-based behavioral health services for children and youth with Serious Emotional Disturbance (SED) who are at risk of psychiatric hospitalization, out-of-home placement, or deeper system involvement.

The HiFi Wrap model is family-centered, strength-based, and culturally responsive, emphasizing the youth and family's *voice and choice* throughout care. Services are individualized to help children remain safely at home, engaged in school, and connected to their natural supports. Using a four-phase model, Engagement, Planning, Action, and Transition. The program delivers coordinated, integrated care that builds family resilience and long-term stability.

Seneca collaborates closely with Napa County Behavioral Health, the Interagency Case Planning (ICP) team, and community partners to improve access, reduce disparities, and ensure cross-system alignment. Through these partnerships, HiFi Wrap supports Napa County's goal of providing equitable, comprehensive behavioral health care for high-need youth and families.

Target Population

The HiFi Wrap program serves children and youth ages 0–18 with complex behavioral health needs who meet FSP eligibility criteria. Priority is given to families with multiple system involvement, particularly those engaged with Child Welfare, Probation, and Educational Services, and to bilingual and bicultural families facing language or cultural barriers to care.

Youth at risk of out-of-home placement, hospitalization, or school disruption receive intensive, wraparound support to stabilize home environments, strengthen family relationships, and develop lasting natural supports.

Key Activities and Services

Activities in FY 23–24 primarily focused on staffing, county collaboration, and office/facility set-up as the program established its operational foundation. Staffing activities included the hiring and onboarding of five full-time staff, participation in orientation and required onboarding trainings, and completion of Wraparound-specific and County trainings, including Credible EHR documentation.

Administrative and leadership staff dedicated significant time to hiring and onboarding program staff and coordinating with centralized agency departments such as Quality Assurance/Quality Improvement (QA/QI), Health Services, Information Technology, Facilities, and Training.

County collaboration efforts with Napa County administrators centered on developing program materials—including promotional materials and referral forms—reviewing and aligning documentation requirements within Credible and establishing key operational processes such as the referral process and participation in Interagency Case Planning (ICP) meetings.

Facility set-up activities involved securing and preparing the program office, which included executing a lease, furnishing the office, and purchasing small appliances, environment-of-care and emergency preparedness supplies, and signage for accessibility and wayfinding. Utilities such as phone lines, internet, water service, and document storage were established. Additional setup expenses covered basic office supplies, electronic equipment (staff laptops, iPhones, DTEN, printers, and scanners/copiers), and therapeutic materials for youth and families, such as arts and crafts supplies, sports equipment, and games to support engagement and skill-building.

Client Demographics and Service Volumes

During the program’s first year, Seneca focused on ramp-up and infrastructure development, including staff recruitment, training, and facility setup prior to full client enrollment. As a result, comprehensive demographic and service volume data for FY 23–24 will be available in the next reporting cycle (FY 24–25) once the program reaches full implementation.

Initial referrals were received through Napa County Behavioral Health, Child Welfare Services, and Probation, with early caseloads reflecting youth at highest risk for out-of-home placement

or psychiatric hospitalization. Program reporting and data collection systems were established within the Credible EHR platform to ensure accurate tracking of service volumes and outcomes moving forward.

Outcome Highlights

Seneca's first-year implementation focused on building program infrastructure, training staff, and strengthening interagency coordination. Families participating in early services reported improved communication, greater confidence in managing behavioral health needs, and stronger natural supports.

The program successfully prevented several potential out-of-home placements through in-home stabilization efforts and enhanced collaboration among Napa County Behavioral Health, Child Welfare Services, and Probation. Bilingual and bicultural staff reduced cultural and language barriers, improving accessibility for Latino/a/x families and supporting equitable outcomes across populations.

Challenges and Adaptations

As with most new program launches, the first year included challenges such as staffing delays, integration into the County's EHR system, and the development of standardized documentation and referral workflows. Through close collaboration with Napa County Behavioral Health, Seneca addressed these challenges by refining internal processes, enhancing training, and improving data management.

Transition Age Youth Full Service Partnership

Program Description

The Transitional Age Youth Full Service Partnership (TAY FSP) program provides intensive, culturally responsive services to youth ages 16–25 in Napa County. The program supports young people facing complex challenges, including mental health conditions, involvement in the juvenile justice system, co-occurring substance use disorders, housing instability, and limited family or community support. Services emphasize building trust, fostering resilience, and ensuring youth and their families have access to resources that promote stability and long-term success.

Target Population

The TAY FSP program serves transitional age youth, including unserved and underserved populations who are at increased risk for homelessness, incarceration, and poor mental health outcomes. The program prioritizes culturally and linguistically responsive care for Latino youth, the largest minority group in Napa County, as well as tailored support for LGBTQ+ identifying youth, particularly transgender clients. Many participants also experience co-occurring substance

use disorders or are involved with Child Welfare or Juvenile Probation. The TAY FSP program provides services for youth ages 16-25.

Key Activities and Services

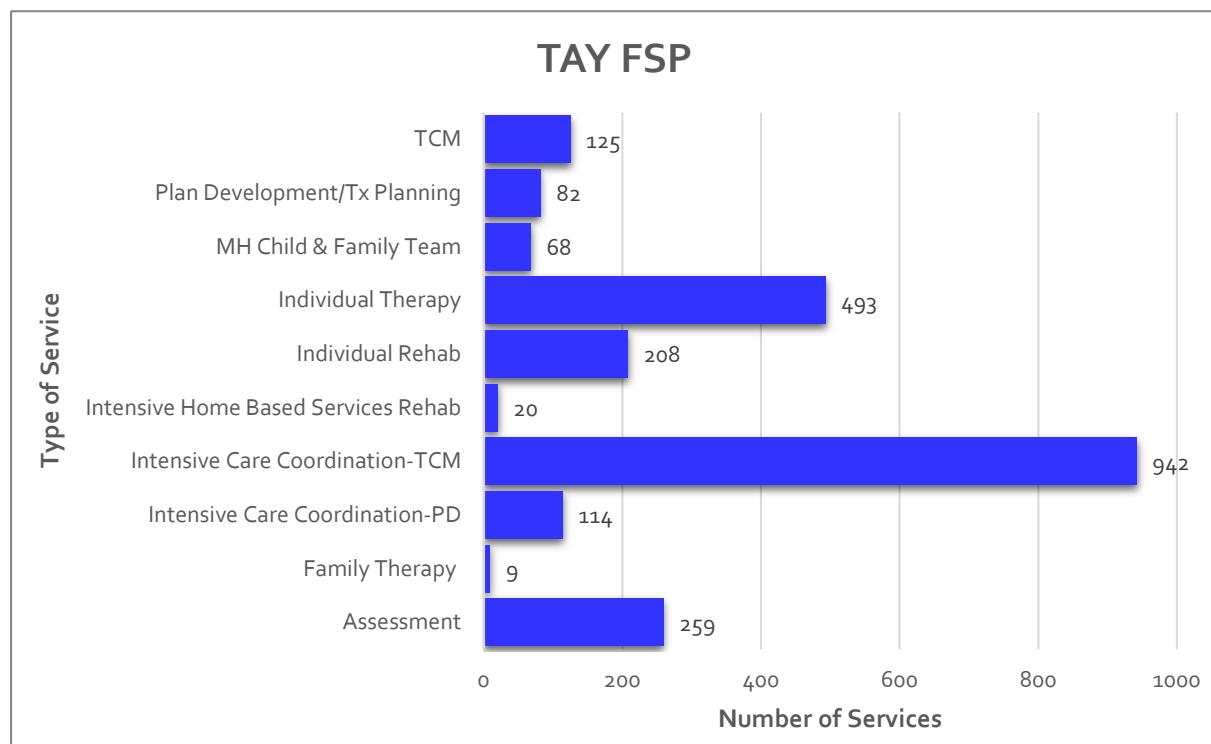
To reduce service disparities, the program has maintained a bilingual and bicultural workforce, including the addition of a part-time bilingual Mental Health Worker Aide (Parent Partner) to support Child and Family Team (CFT) meetings, provide parent psychoeducation, and assist families in navigating school-based services such as IEPs and 504 plans. Staff have strengthened their skills through Trusted Messenger and Interpreter Trainings, as well as specialized training in eating disorder assessment and treatment.

The TAY FSP program maintains strong partnerships with community agencies to ensure continuity of care and coordinated support. Close collaboration with Juvenile Probation and Juvenile Hall has resulted in smoother transitions for justice-involved youth, while ongoing partnership with Camille Creek Community School has fostered joint efforts to reduce recidivism and improve probation outcomes. To meet the needs of LGBTQ+ youth, staff have pursued additional training, expanded connections with affirming services, and provided families with psychoeducation to foster acceptance and support.

Given the high prevalence of co-occurring disorders, clinicians frequently coordinate with alcohol and drug service providers, inviting them into CFT or multidisciplinary team meetings when appropriate, and supporting referrals to residential treatment when stabilization is needed. The team also continues to address significant housing barriers, connecting families with local programs, and when resources are unavailable, using flex funds for rental assistance, treatment fees, or basic stabilization. In addition, TAY FSP staff support youth with employment connections and skills development to promote self-sufficiency.

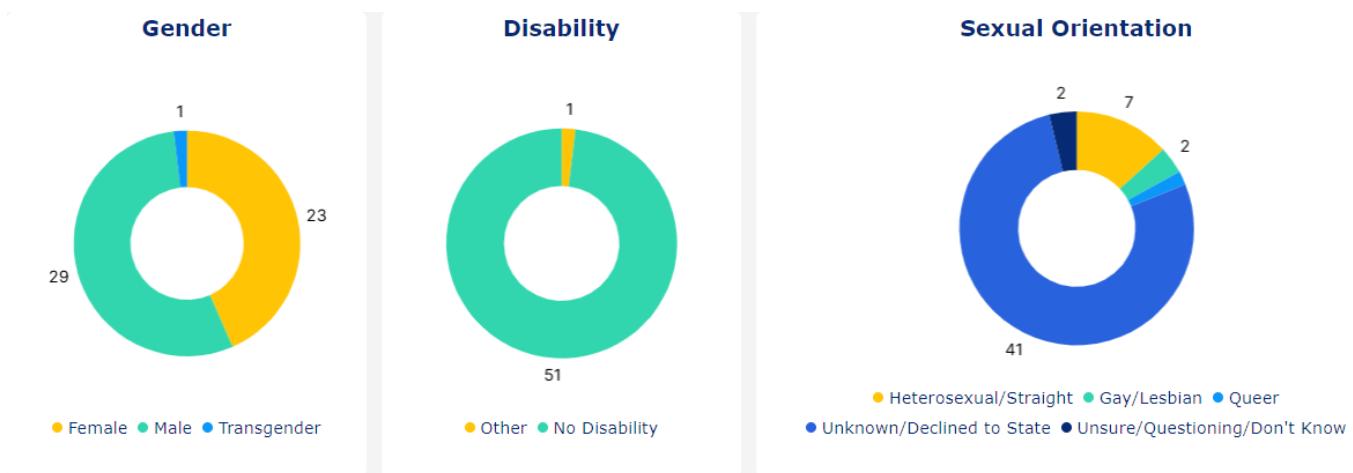
Client Demographics and Service Volumes

For FY23-24, Napa County Behavioral Health provided services to a total of 53 participants enrolled in the TAY FSP program. The following graph and tables provide an overview of the number of services delivered, as well as the demographic characteristics of the transition age youth served.



Demographics





Estimated individuals served and cost per client:

TAY FSP

Age	FY 23-24 Individuals Served	FY 24-25 Projected Individuals Served	FY 25-26 Projected Individuals Served
0-15 Children/Youth	0	0	0
16-25 TAY	53	67	50
26-59 Adult	0	0	0
60+ Older Adult	0	0	0
Total	53	67	50
Funding	\$768,883	\$792,527	\$942,885
Cost per client	\$14,507.22	\$11,828.77	\$18,857.70

Outcome Highlights

Over FY 23-24, the TAY FSP program helped youth achieve stability across multiple domains, including mental health, housing, education, and employment. Many clients successfully graduated from FSP-level services and transitioned to lower levels of care, or in some cases, concluded services altogether due to achieving sufficient stability. Having a fully staffed team increased service capacity, allowing the program to reach more individuals while incorporating a wide range of staff specialties. Strong rapport with youth, caregivers, and community partners

strengthened the program's reputation, with agencies regularly reaching out for referrals or consultation when youth are in crisis.

To address an increase in eating disorders, staff attended a two-day training course to strengthen assessment and treatment skills, and the team established partnerships with medical providers and dietitians to ensure comprehensive care and monitoring. To better serve the LGBTQ+ community, especially transgender youth, clinicians attended specialized trainings, built connections with affirming support services, and advocated for youth to access care that reduces risk factors. Clinicians and support staff also provided families with psychoeducation and guidance to increase acceptance and support, improving outcomes for both youth and their families.

Challenges and Adaptations

Persistent challenges for the TAY-FSP program include limited affordable housing, the instability of youth and families even after housing is secured, and the complex needs of young people with co-occurring disorders. Rising costs of living, limited income, and employment instability often make it difficult for clients to maintain stable housing. In response, the team actively seeks out new housing resources and collaborates with residential treatment program staff to support youth as they transition between levels of care. Support staff play a key role in linking families with community agencies that provide housing assistance, while flex funds are used strategically to cover rental support, offset residential treatment fees while SSI applications are pending, and address urgent financial hardships.

The program has also expanded its focus on strengthening long-term stability. Providers assist clients with connecting to employment resources and implementing interventions that build self-sufficiency skills. At the same time, the team continues to prioritize a bilingual and bicultural workforce and family engagement through the addition of a parent partner. Staff have enhanced their expertise through advanced training in trauma, eating disorders, and culturally responsive care, including supports tailored to LGBTQ+ youth. Strong partnerships with probation, schools, health providers, and substance use services further ensure that services are comprehensive and coordinated. Flex funds remain a critical tool for bridging service gaps, while the team's strong community presence and commitment to "whatever it takes" ensures youth and families receive individualized, flexible care that addresses barriers and promotes long-term success.

Adult Full Service Partnership

Program Description

The Adult Full Service Partnership (AFSP) program provides intensive, recovery-oriented services for adults diagnosed with severe mental illness who are unhoused or at risk of losing their housing. Operating as a multidisciplinary team, AFSP collaborates closely with County-contracted community-based organizations (CBOs) to ensure comprehensive and coordinated care. Services include intensive case management, individual rehabilitation, therapy, and housing support

tailored to each consumer's unique needs. The team is composed of bilingual English and Spanish speaking staff, both male and female, to meet consumer preferences and reduce cultural and language barriers. The program's approach is rooted in whole-person wellness, addressing mental health, housing stability, and the social factors that impact recovery.

Target Population

The AFSP program serves adults ages 18 and older who have been diagnosed with severe mental illness and are either unhoused or at risk of homelessness. Many consumers face additional challenges such as substance use, justice involvement, or limited natural support. The program also prioritizes outreach to unserved and underserved populations, with a focus on Spanish speaking and racially and ethnically diverse individuals who often experience disproportionate barriers to accessing mental health and housing services.

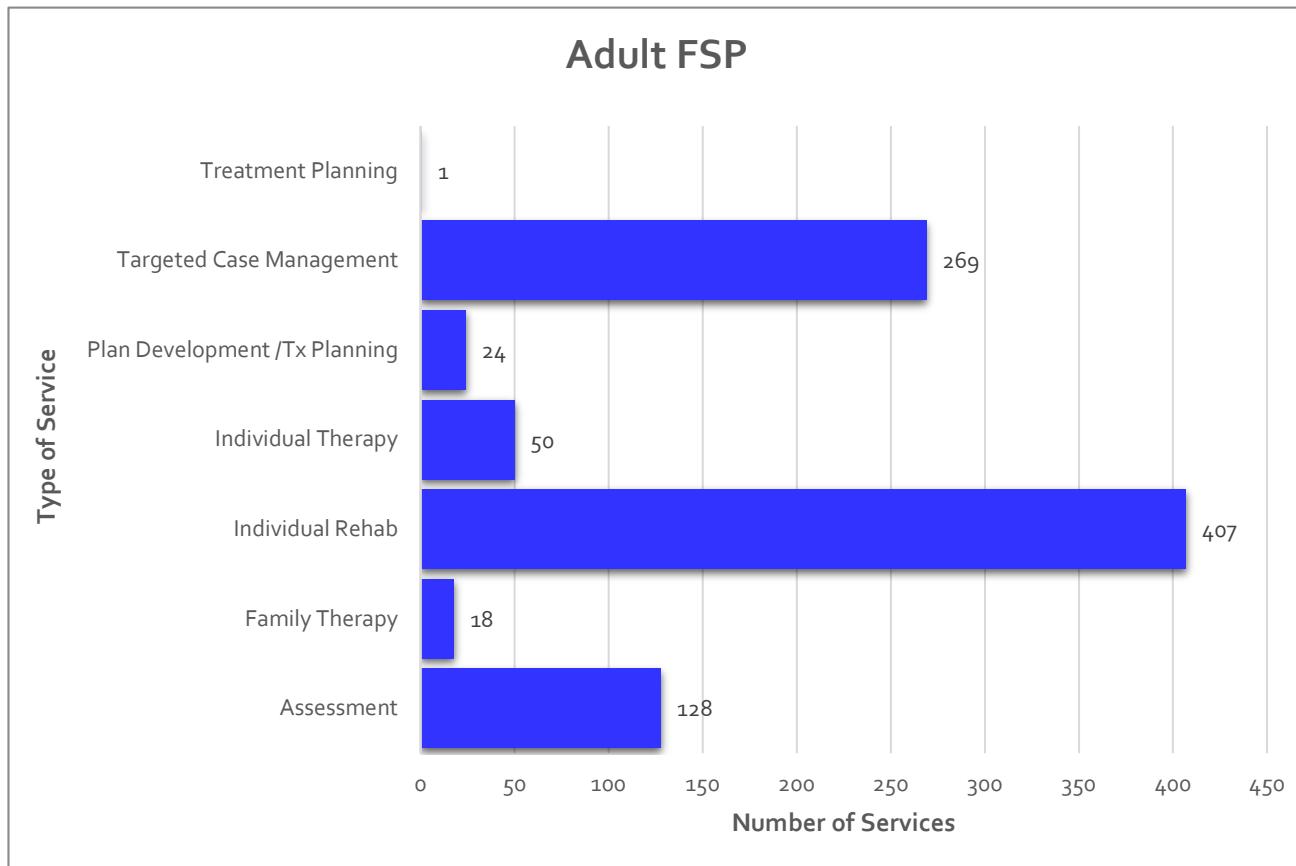
Key Activities and Services

Throughout FY 23–24, AFSP staff provided individualized services that included ongoing case management, rehabilitation, therapy, and linkage to community-based resources. The team worked collaboratively with Napa County Housing and Homeless Services and CBOs such as Abode, Progress Foundation, Mentis, and Fresh Start to expand access to stable housing opportunities for clients. AFSP also partnered with the Napa County Department of Corrections to support justice-involved consumers by conducting in-custody visits, developing individualized release plans to address re-entry needs, and coordinating transitions to community-based services. Linkages to programs such as Progress Place, a crisis residential facility, provided critical stabilization and mental health support that helped reduce recidivism and promote long-term recovery.

In addition, the AFSP program engaged in significant community outreach, participating in countywide events such as the Mental Health Resource Fair, Mixteco Resource Fair, Pride in the Park, Earth Day, and Kids Day. AFSP also introduced a weekly “Diversity Corner” during staff meetings, where staff shared topics related to Race, Equity, Inclusion, Diversity, and Belonging (REIDB) to build cultural humility and improve service delivery.

Client Demographics and Service Volumes

For FY23-24, Napa County Behavioral Health provided services to a total of 50 participants enrolled in the Adult FSP program. The following graph and tables provide an overview of the number of services delivered, as well as the demographic characteristics of the adults served.



Demographics

Total Clients Served:

50

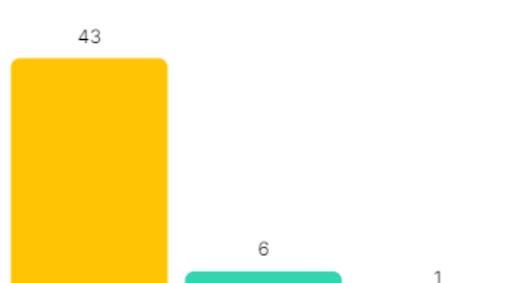
Age Total

Age

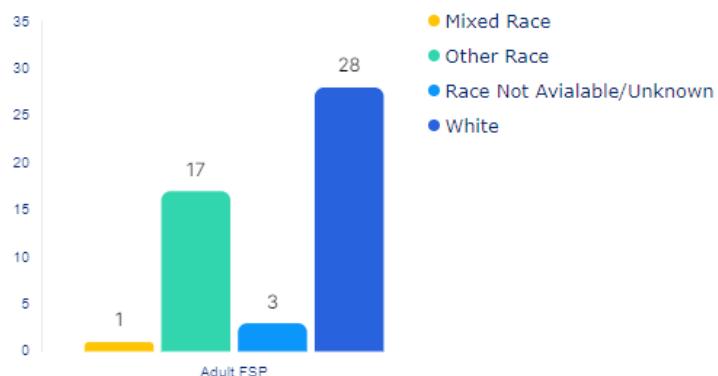


● Adult (26-59)

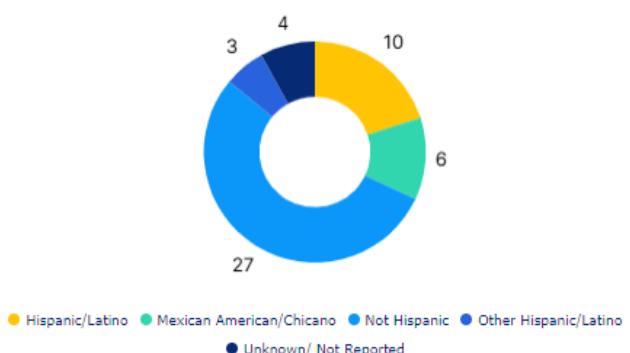
Language



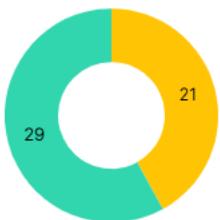
Race



Ethnicity

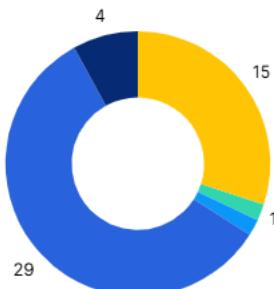


Gender



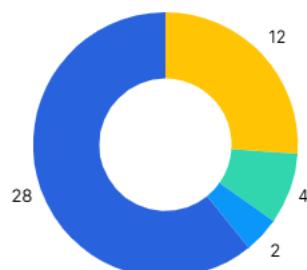
● Female ● Male

Sexual Orientation



● Heterosexual/Straight ● Gay/Lesbian ● Bi-Sexual
● Unknown/Declined to State ● Unsure/Questioning/Don't Know

Disability



● Mental (excluding: Mental Illness) ● Physical/Mobility ● Other
● No Disability

Estimated individuals served and cost per client:**Adult FSP**

Age	FY 23-24 Individuals Served	FY 24-25 Projected Individuals Served	FY 25-26 Projected Individuals Served
0-15 Children/Youth	0	0	0
16-25 TAY	0	0	0
26-59 Adult	50	57	60
60+ Older Adult	0	0	0
Total	50	57	60
Funding	\$1,354,086	\$1,014,794	\$1,797,230
Cost per client	\$27,081.72	\$17,803.40	\$29,953.83

Outcome Highlights

The AFSP program achieved several important outcomes during the FY 23-24. Outreach and engagement efforts were sustained and expanded across a wide range of community events, reaching both English and Spanish speaking community members. Collaborations with housing providers were strengthened, which improved client access to supportive housing options. For justice-involved consumers, coordinated planning and connections to stabilization services helped reduce recidivism and improved re-entry success. The program also enhanced its capacity to serve culturally and linguistically diverse populations through the addition of bilingual staff and ongoing REIDB learning.

AFSP remains a strength-based program that focuses on the individual's goals for recovery and overall quality of life. Services are centered on each person's unique needs, and staff work intentionally to engage individuals in their own care, meeting them "where they are." The team strives to foster hope and build on each consumer's resilience, ensuring that the program is not only clinically effective but also empowering and person-centered. These efforts collectively contribute to improved mental health, housing stability, and whole-person wellbeing for some of the most vulnerable adults in Napa County.

Challenges and Adaptations

Despite its successes, the AFSP program continues to face significant challenges. A persistent shortage of housing resources has limited options for many consumers, requiring the team to work creatively with available programs and advocate for expanded housing supports.

Coordination for justice-involved consumers remains complex, with timely planning and cross-agency collaboration needed to prevent re-entry into custody.

Sustaining outreach efforts also requires continued investment of staff time and resources to remain visible and accessible in diverse community spaces. In response to these challenges,

AFSP has adapted by strengthening its partnerships with housing providers and residential treatment programs, enhancing cultural responsiveness through staff training and REIDB discussions, and leveraging collaborative relationships with CBOs and County programs to bridge service gaps. These adaptations have allowed the program to remain flexible and responsive while continuing to support adults with severe mental illness in achieving stability and recovery.

Adult Treatment Team Full Service Partnership

Program Description

The Adult Treatment Team Full-Service Partnership (ATT FSP) provides intensive, individualized services to adults with severe mental illness who are transitioning through the continuum of care, including psychiatric hospitals, locked facilities, and enhanced board and care homes. During FY 23–24, ATT served 27 consumers, reflecting a slight increase over FY 22–23. This increase is linked to the growing number of individuals being psychiatrically hospitalized, navigating the LPS process, and those with justice involvement. The program has also seen increased referrals from individuals stepping down from locked facilities into enhanced board and care homes. Given the critical need for ongoing support, ATT FSP plays an essential role in helping individuals avoid returning to locked facilities or psychiatric hospitals by providing the necessary interventions to promote stability, recovery, and successful reintegration into the community.

Target Population

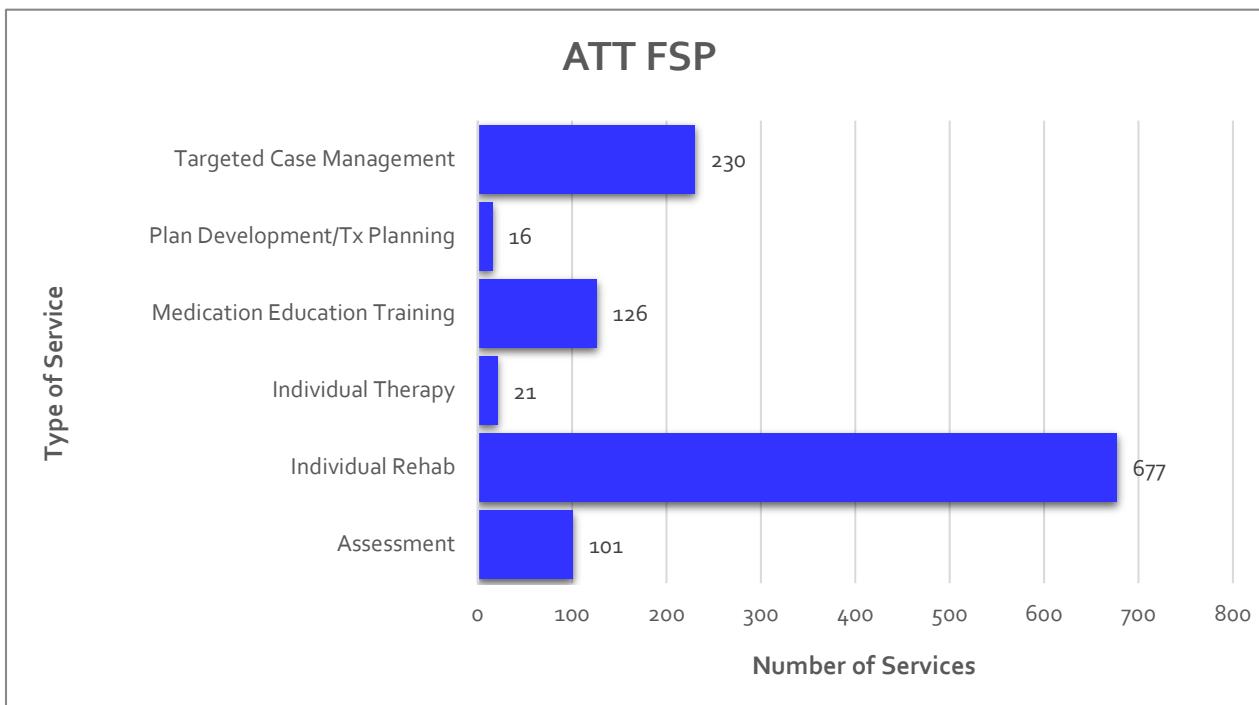
The ATT FSP serves Medi-Cal recipients who are currently or have recently been psychiatrically hospitalized or incarcerated and are at risk of re-entering higher levels of care without adequate support. Many participants are justice-involved, including individuals on probation, who require intensive case management and wraparound services. The program prioritizes individuals stepping down from locked facilities into enhanced board and care homes and other transitional settings, ensuring that they have the resources and support needed to sustain recovery and reduce the risk of relapses, homelessness, or re-incarceration.

Key Activities and Services

The ATT FSP program focuses on bridging system gaps by providing services during and after psychiatric hospitalization or incarceration. Staff connect with individuals while in the hospital to develop care coordination plans that support successful discharge and ongoing service engagement. Upon re-entry into the community, consumers are offered case management services from ATT clinicians, who assist with linkages to behavioral health care, housing supports, and community resources that reinforce stability and independence. Flex funds are also used to help individuals meet essential needs, setting them up for success during critical transition periods. Increasingly, the program has supported individuals with forensic involvement, tailoring services to address their unique needs and reduce the likelihood of recidivism.

Client Demographics and Service Volumes

For FY 23-24, a total of 34 participants were enrolled in the Adult Treatment Team FSP program. The following graph and tables provide an overview of the number of services delivered, as well as the demographic characteristics of the adults served.



Demographics

Total Clients Served:

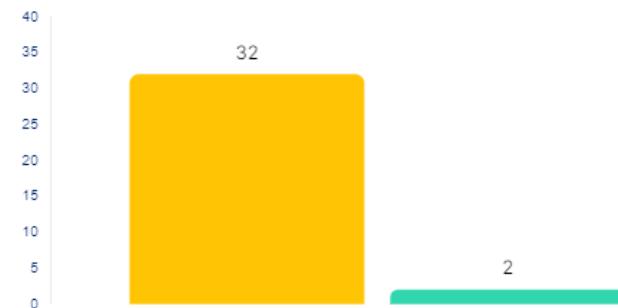
34

Age

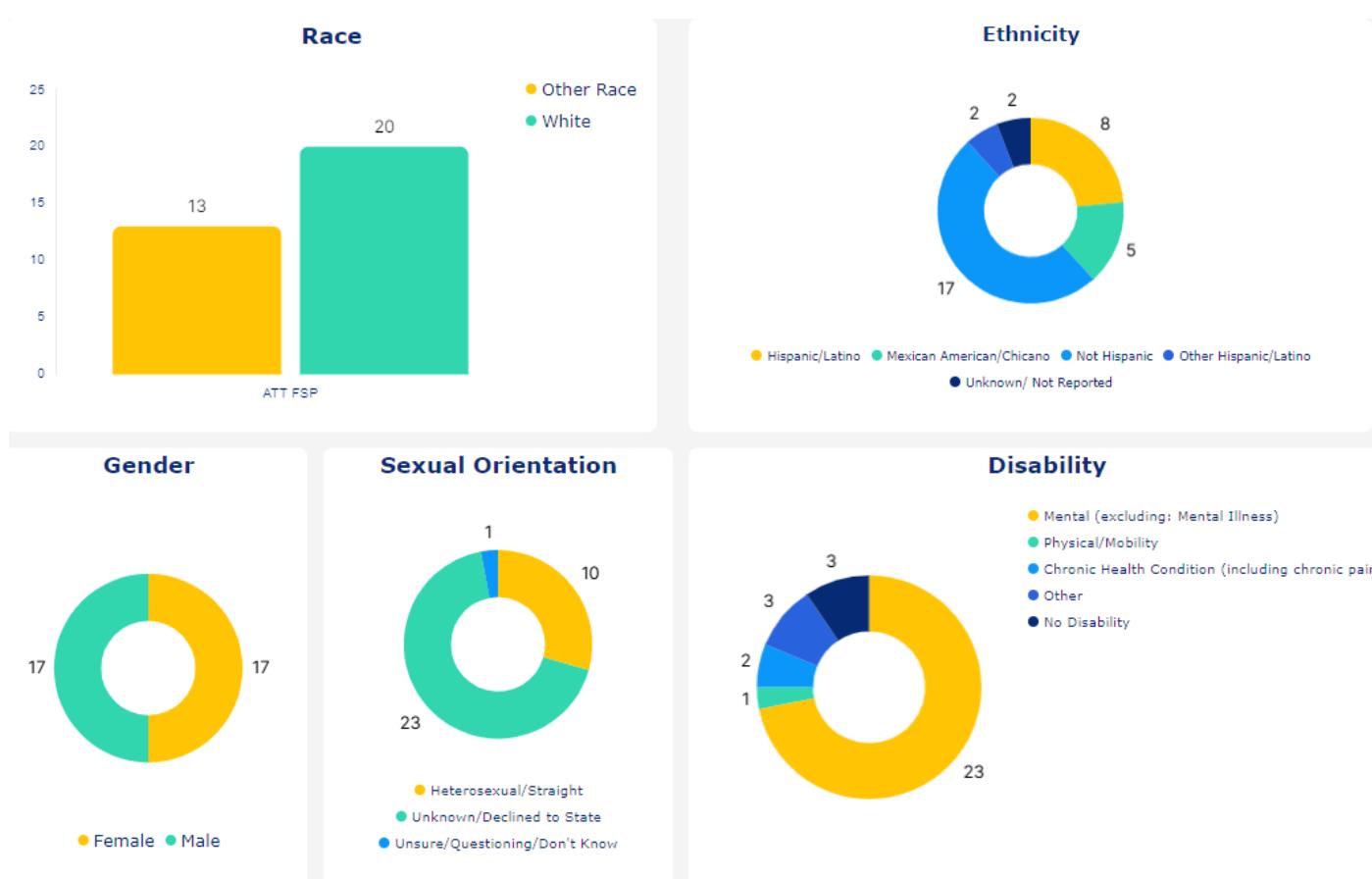


● Adult (26-59) ● Older Adult (60+)

Language



● English ● Spanish



Estimated individuals served and cost per client:

ATT FSP

Age	FY 23-24 Individuals Served	FY 24-25 Projected Individuals Served	FY 25-26 Projected Individuals Served
0-15 Children/Youth	0	0	0
16-25 TAY	0	0	0
26-59 Adult	30	35	25
60+ Older Adult	4	0	0
Total	34	35	25
Funding	\$931,474	\$619,205	\$752,772
Cost per client	\$27,396.29	\$17,691.57	\$30,110.88

Outcome Highlights

The ATT FSP continues to demonstrate its role as a vital program for reducing hospitalizations, recidivism, and system cycling among adults with severe mental illness. By connecting with individuals during hospitalization and providing seamless support upon discharge, the program increases service engagement and helps participants stabilize in the community. Case managers engage participants in recovery-oriented care, focusing on long-term goals such as housing stability, sobriety, education, and employment readiness. Flex funding has been critical in supporting participants' basic needs and empowering them to achieve milestones that foster independence and confidence.

A notable success during FY 23–24 involved supporting a consumer transitioning from an Adult Residential Rehabilitation Facility program to Bella House, a one-year transitional housing program operated by Progress Foundation. With the support of ATT FSP, she obtained basic necessities that improved her confidence and self-image. She has since been accepted into Fresh Start, where she continues to develop her independent living skills and pursue long-term goals of returning to college and regaining employment skills. This individual has maintained sobriety, is set to graduate from Alcohol and Drug Services, secured Supplemental Security Income (SSI), and continues to actively engage with her case manager while working toward independent living.

Challenges and Adaptations

The ATT FSP program continues to face challenges related to the increasing number of individuals cycling through psychiatric hospitals, the LPS process, and justice involvement. Many participants require intensive case management and higher levels of support than in previous years, particularly those with forensic involvement or complex discharge needs. Additionally, limited housing options remain a barrier to long-term stability for many participants.

In response, ATT FSP has adapted by strengthening partnerships with hospitals, correctional facilities, and transitional housing providers to ensure smooth transitions into the community. The program also leverages flex funds strategically to reduce barriers and support participants in building stability. Through these adaptations, ATT FSP continues to provide critical interventions that reduce recidivism to higher levels of care, promote recovery, and support participants in achieving their personal goals.

Older Adult Treatment Team Full Service Partnership

Program Description

The Older Adult Full Service Partnership (OA FSP) provides intensive, individualized services to underserved, at-risk adults aged 60 and older. In FY 23–24, the program served 38 clients, beginning with assessments that identified each individual's specific needs, challenges, and

personal goals for recovery. Many participants are medically fragile and at risk of placement in Skilled Nursing Facilities (SNFs), while others experience co-occurring medical or substance use disorders, personality disorders, or bio-psycho-social challenges that require tailored interventions. A significant number of older adults served are unhoused or at serious risk of homelessness, further heightening their vulnerability. The OA FSP program is designed to meet these complex needs by addressing mental health while also supporting emotional, social, housing, and nutritional stability.

Target Population

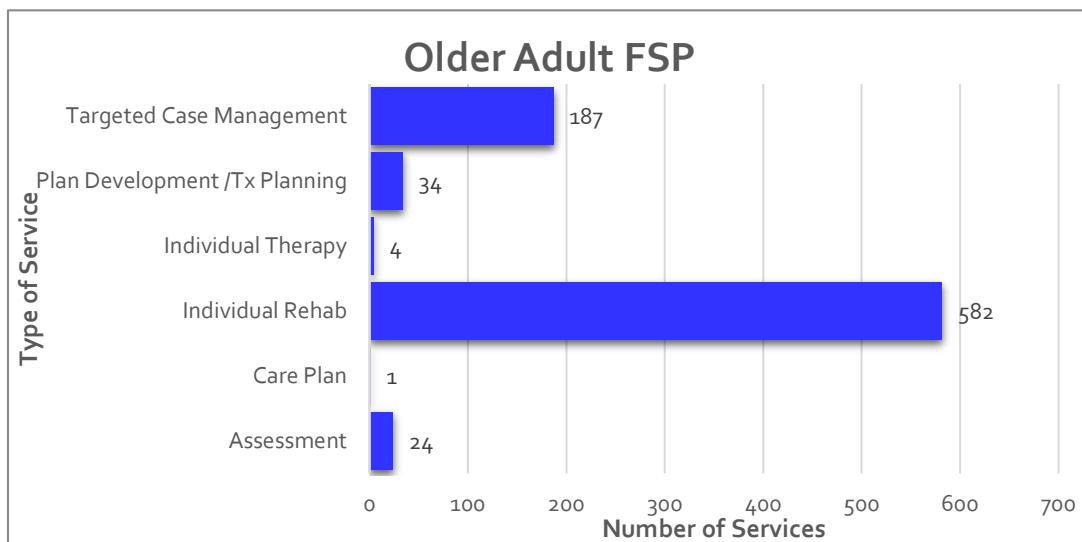
The OA FSP serves adults aged 60 and older who are living with severe mental illness and often co-occurring health or substance use conditions. Many are medically fragile, socially isolated, or facing challenges that place them at risk of Skilled Nursing Facility placement, homelessness, or loss of independence. The program prioritizes underserved older adults who might otherwise go without adequate mental health services, particularly those navigating multiple barriers related to health, housing, and access to culturally responsive care.

Key Activities and Services

The OA FSP provides a wide range of supports to meet the unique needs of older adults. Services include counseling to address both physical and emotional challenges, development of individualized goals, and referrals or linkages to psychiatric medication management, medical care, housing resources, food assistance, and opportunities for social connection. Staff also help arrange transportation to appointments, coordinate with in-home support services, and conduct fall risk assessments to promote safety. In addition, the program assists clients in accessing financial and health benefits, ensuring they are better equipped to manage their daily lives and sustain stability.

Client Demographics and Service Volumes

For FY23-24, a total of 44 participants were enrolled in the Older Adult Treatment Team FSP program. The following graph and tables provide an overview of the number of services delivered, as well as the demographic characteristics of the older adults served.



Demographics

Total Clients Served:

44

Age

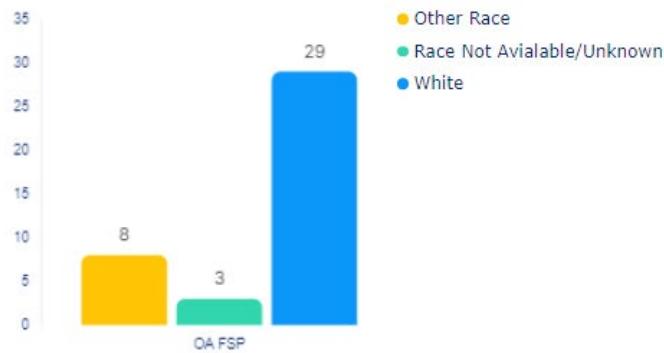


● Older Adult (60+)

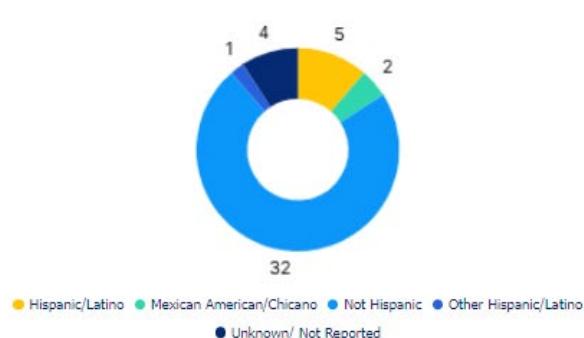
Language



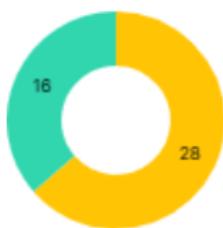
Race



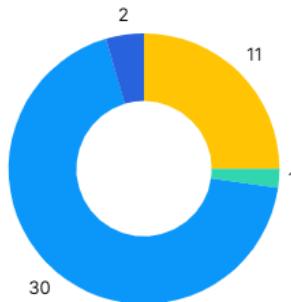
Ethnicity



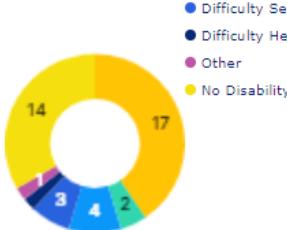
Gender



Sexual Orientation



Disability



● Female ● Male

● Heterosexual/Straight ● Gay/Lesbian ● Unknown/Declined to State
● Unsure/Questioning/Don't Know

Estimated individuals served and cost per client:**Older Adult FSP**

Age	FY 23-24 Individuals Served	FY 24-25 Projected Individuals Served	FY 25-26 Projected Individuals Served
0-15 Children/Youth			
16-25 TAY			
26-59 Adult			
60+ Older Adult	44	43	50
Total	44	43	50
Funding	\$570,360	\$704,966	\$1,032,016
Cost per client	\$12,962.73	\$16,394.56	\$20,640.32

Outcome Highlights

The OA FSP program has demonstrated strong outcomes in promoting stability and recovery among older adults with complex needs. Through coordinated care and wraparound supports, participants who would otherwise face homelessness, untreated medical and mental health symptoms, or social isolation have been linked to HHSA Mental Health and Substance Use programs, medical oversight, and social services. Many participants have successfully stabilized their mental health, obtained housing in board and care facilities, or transitioned to independent living and private apartments. By focusing on individualized goals, supporting both mental health and social determinants of health, and providing culturally responsive care, OA FSP has helped older adults achieve greater independence, safety, and quality of life.

Challenges and Adaptations

Despite successes, the OA FSP program continues to face challenges in securing appropriate placements for older adults with complex needs, such as mobility limitations, substance use, continence issues, or behavioral challenges. Even when mental health symptoms are stabilized, some participants struggle to meet program requirements related to medication management, sobriety, or daily living skills, leading to placement failures. To address these barriers, OA FSP staff collaborate with multiple community agencies and participate in interdisciplinary teams to identify creative solutions and appropriate levels of care. Through these collaborative efforts, several participants were successfully placed in supportive housing and maintained stability with the right level of assistance. These adaptations highlight the program's flexibility and commitment to meeting older adults "where they are" to promote recovery and dignity.

Community Services and Supports: Project Access Outreach and Engagement Programs

Project Access encompasses a series of Outreach and Engagement strategies within the CSS component, designed to increase access to mental health services and support individuals and families in need throughout Napa County. These programs focus on engaging unserved and underserved populations, strengthening connections to care, and reducing barriers that prevent individuals from accessing timely and appropriate behavioral health services.

Project Access includes the following key programs:

- **System Navigators Outreach and Engagement**
- **Innovations Community Center (ICC)**
- **ParentsCAN (PCAN)**
- **Co-Occurring**

Due to overlapping populations and shared service delivery among these programs, some duplication of services occurs, making demographic data less reliable for detailed analysis.

The Project Access strategies align with the guiding principles and goals of the Mental Health Services Act (MHSA) and Napa County Health and Human Services' commitment to equity, wellness, and recovery. These strategies emphasize:

- Expanding outreach and access to better reflect the prevalence and cultural diversity of Napa County's population.
- Increasing consumer- and peer-operated programs, including drop-in centers, warm lines, crisis response, case management, self-help, and family partnership initiatives.
- Reviewing and modifying service policies and practices to better support individuals in achieving recovery and personal goals.
- Providing coordinated, person-centered care for individuals with co-occurring mental health and substance use disorders through integrated screening, assessment, and individualized planning.
- Promoting collaboration with community partners to enhance service integration and develop creative, recovery-focused approaches that advance health, independence, and self-sufficiency.
- Reducing the negative impacts of untreated mental illness, such as homelessness, incarceration, hospitalization, suicide, and unemployment.

The following sections provide an overview of each Project Access Outreach and Engagement Program.

CSS Outreach and Engagement – Project Access Program:

System Navigators Outreach and Engagement

Target Population:

Individuals and families throughout Napa County who are unserved, underserved, or inappropriately served, particularly those facing barriers to accessing behavioral health services. The program places a strong emphasis on reaching Latino/a/x and other culturally diverse community members through bilingual and bicultural staff.

Program Description and Goals:

As a key component of Project Access, the System Navigators program provides direct outreach and engagement services designed to connect individuals and families to behavioral health and community resources. The program's primary goal is to improve access to care by reducing cultural, linguistic, and systemic barriers, while promoting early engagement, recovery, and wellness.

System Navigators serve as trusted guides, helping community members understand and access available services, navigate complex systems, and connect with supports that promote stability and self-sufficiency.

The program's goals align with the guiding principles of MHSA by:

- Expanding outreach and engagement to reflect the cultural and linguistic diversity of Napa County.
- Promoting early intervention and recovery through person-centered approaches.
- Increasing service access for individuals with co-occurring needs.
- Building community partnerships that strengthen the behavioral health system of care.

Key Activities and Services:

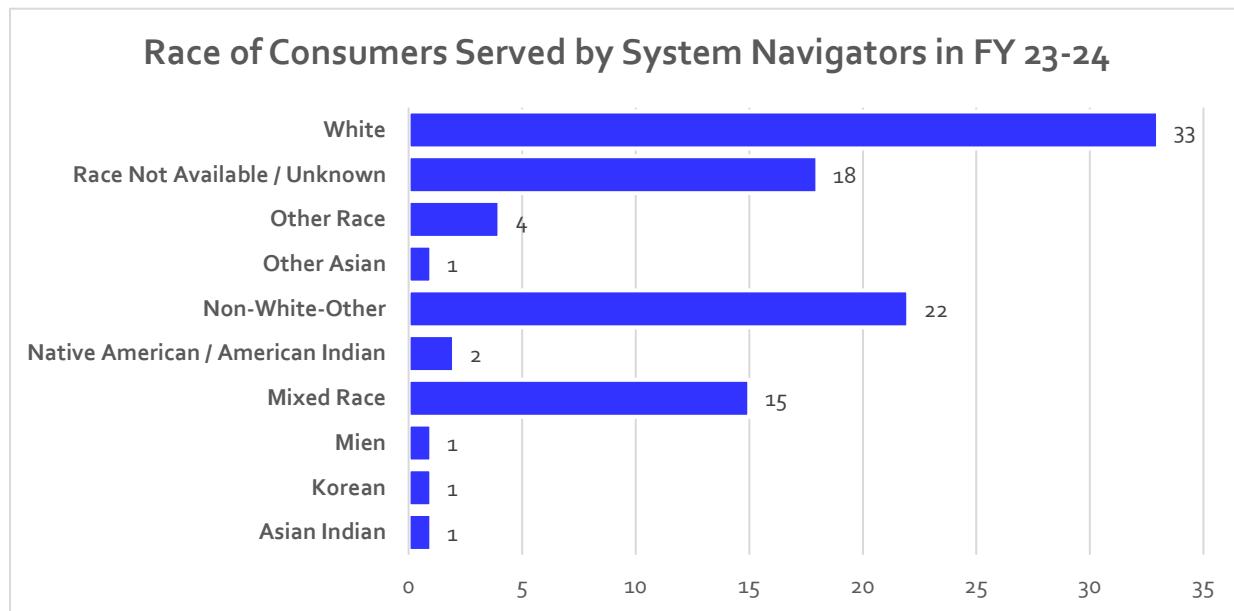
System Navigators provide a wide range of outreach and engagement activities throughout Napa County to ensure residents are aware of and connected to available behavioral health and community resources. Staff participate in community events, health fairs, and outreach activities to meet individuals where they are, providing information, resources, and warm handoffs to behavioral health services. The program offers culturally responsive navigation and referral support, ensuring individuals can access Medi-Cal, CalFresh, healthcare, housing, and other essential services.

In addition to outreach, System Navigators provide limited case management for individuals who need short-term assistance to overcome barriers and stabilize their circumstances. These case management services, typically lasting up to 60 days, are focused on linking individuals to the appropriate programs or agencies that can provide ongoing care. The program also assists with transportation, coordination of appointments, and follow-up support to ensure successful service connection.

System Navigators collaborate closely with community-based organizations, healthcare providers, and county programs to strengthen referral pathways and reduce service duplication. By maintaining strong partnerships and open communication with other service providers, the program enhances coordination of care and ensures that residents receive timely and comprehensive support.

Client Demographics and Service Volumes

In FY 23-24, System Navigators provided 98 individuals with case management services. Of the 98 individuals, 40 identified as male, 50 as female, 5 transgender, and 3 identified as other. About 98% of individuals served identified their ethnicity as Latino/Hispanic/Mexican/Chicano.



In FY 23–24, System Navigators continued to strengthen outreach and engagement efforts across Napa County. Staff participated in community events, collaborated with local organizations, and provided individualized navigation support to residents seeking mental health and related services. Through culturally competent and bilingual outreach, the program successfully connected numerous individuals to Medi-Cal, CalFresh, housing, and behavioral health resources.

The short-term case management model—providing up to 60 days of targeted support—proved effective in helping individuals stabilize and transition into appropriate levels of care. The

program's community-based approach fostered trust, reduced stigma around seeking help, and supported earlier engagement in behavioral health services.

Challenges and Adaptations:

System Navigators continued to face challenges related to the growing demand for services and limited availability of affordable housing and local treatment resources. Some individuals required longer-term support than the program could provide under its short-term model, highlighting ongoing needs for expanded case management capacity and interagency coordination.

In response, the program strengthened partnerships with community organizations and leveraged collaborative efforts to enhance referrals and follow-up support. Staff also continued to adapt outreach strategies to better reach rural and underserved areas, ensuring equitable access to services across the county.

System Navigator Community Outreach

The table below list the various community outreach events attended by System Navigators in 2024. The number of individuals reached through these events are estimates. The Navigators also had one-time contact with **112 individuals** who did not respond to follow-up outreach and were not interested in case management.

System Navigator Outreach Events – 2024	Event Date	Attendees
Planned Parenthood Presentation	2/23/2024	15
Mixteco Resource Fair	3/17/2024	81
Community Health Fair	4/7/2024	151
On the Verge Presentation	4/11/2024	17
Earth Day Napa	4/20/2022	163
UpValley Family Centers Health Fair	5/29/2024	33
Mental Health Resource Fair	5/31/2024	44
Community Health Fair	6/5/2024	40
Health and Wellness Fair	6/12/2024	35
Meet Me in the Street	6/12/2024	167
Napa Creek Manor Annual Health Fair	6/14/2024	31
Meet Me in the Street	7/10/2024	64
Dia de la Familia	7/21/2024	211
National Night Out	8/6/2024	70
Meet Me in the Street	8/14/2024	194
Back to School Community Celebration (UpValley Family Centers)	8/30/2024	167
Total estimated outreach contacts		1483

CSS Outreach and Engagement – Project Access Program:

Innovations Community Center

Target Population

The Innovations Community Center (ICC), operated by On The Move, serves adults and older adults in Napa County who are living with or recovering from mental health challenges. The program primarily reaches low-income, underserved, and culturally diverse residents, including Spanish-speaking participants and individuals with limited access to traditional mental health services. ICC provides a welcoming, stigma-free space that promotes wellness, community connection, and recovery through art, creativity, and holistic healing.

Program Description and Goals

The Innovations Community Center (ICC) is a consumer-staffed, peer-led program dedicated to supporting individuals on their paths to recovery and emotional well-being. The Center provides a safe, caring, and inclusive environment that fosters creativity, social connection, and empowerment. By integrating art, wellness, spirituality, and community engagement, ICC helps participants rediscover their strengths and take active roles in their healing journeys.

The program model is built around five interwoven “wellness strands” that guide programming and support holistic growth:

- **Art Expression:** Creative outlets such as painting, music, dance, theater, and writing that foster emotional expression and healing.
- **Healthy Living:** Activities that promote mind-body wellness, including exercise, gardening, cooking, and nutrition education.
- **Spiritual Healing:** Mindfulness, meditation, yoga, Tai Chi, and support groups that nurture inner calm and self-awareness.
- **Social Connections:** Daily check-ins, community gatherings, field trips, and special events that build belonging and reduce isolation.
- **Community Engagement:** Leadership opportunities, volunteer roles, and peer mentoring that cultivate self-confidence and purpose.

Program Goals:

- Provide a safe and inclusive space for connection, recovery, and creativity.
- Empower participants through peer-led activities and leadership development.
- Reduce social isolation and stigma by fostering belonging and mutual support.
- Promote holistic wellness through physical, emotional, and spiritual practices.
- Strengthen recovery through peer connection and community participation.

Key Activities and Services

During FY 23–24, ICC offered 1,749 recovery-oriented activities, including art workshops, peer groups, movement and mindfulness classes, and social gatherings.

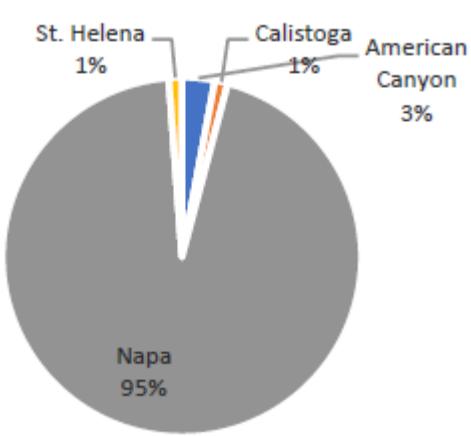
- **376 unduplicated participants** engaged in services, and an additional **256 community members** connected through outreach events, bringing the total to **632 individuals** served during the fiscal year.
- **89%** of participants engaged in two or more services, demonstrating strong retention and engagement.
- **43 individuals** participated in more than 100 services; these “core” members often view ICC as their wellness home.
- **93 participants (25%)** received individualized peer coaching to set recovery goals, strengthen coping skills, and connect to community resources.
- **78 participants (21%)** served as volunteers, peer mentors, or class facilitators, contributing to ICC’s peer-led structure and community-driven approach.

ICC offered 35 unique program elements across its wellness strands, with eight delivered entirely in Spanish. Nearly half (45%) of activities focused on building social connections, reflecting ICC’s emphasis on reducing isolation and strengthening community bonds.

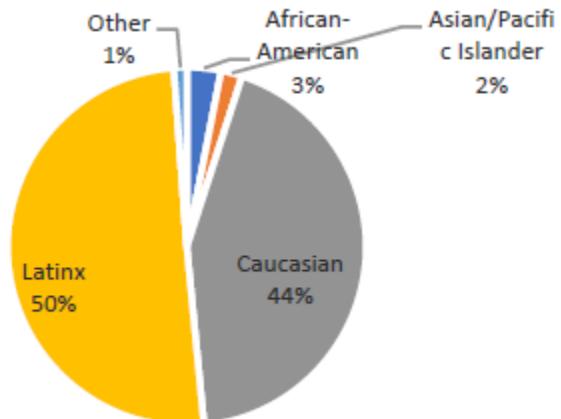
Client Demographics and Service Volumes (FY 23–24)

ICC serves a broad cross-section of Napa County residents that reflects the community’s cultural and socioeconomic diversity.

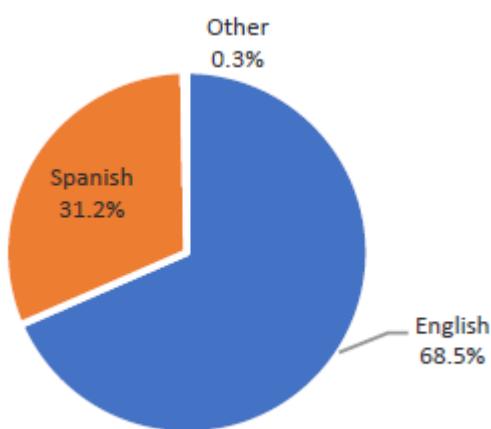
Participants by Region



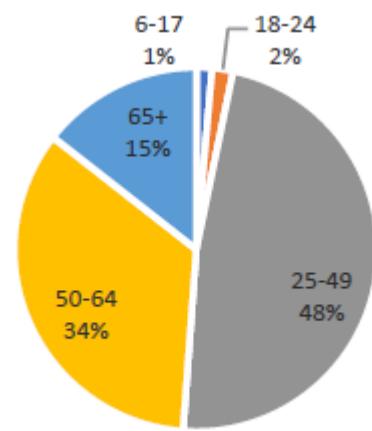
Participants by Race



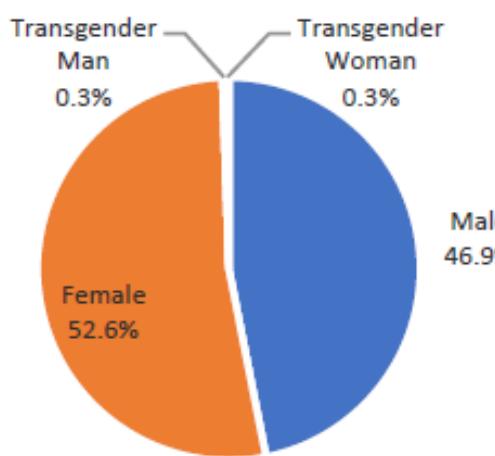
Participants by Primary Language



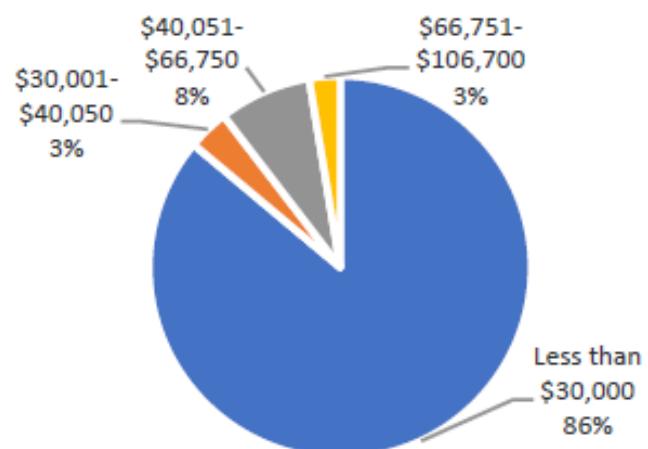
Participants by Age



Participants by Gender

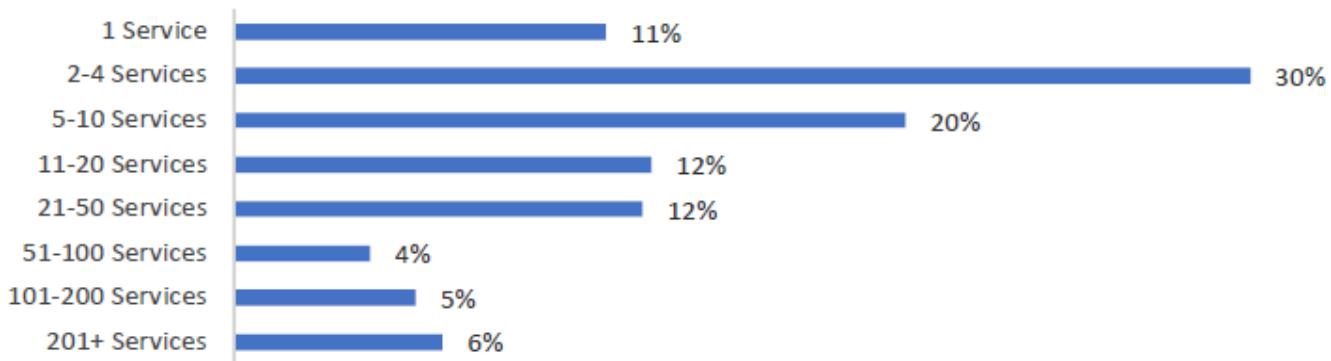


Participants by Income Level



Participants Engagement

The number of core participants (those attending 20 or more activities) continued to grow, reflecting increasing engagement and sustained participation.

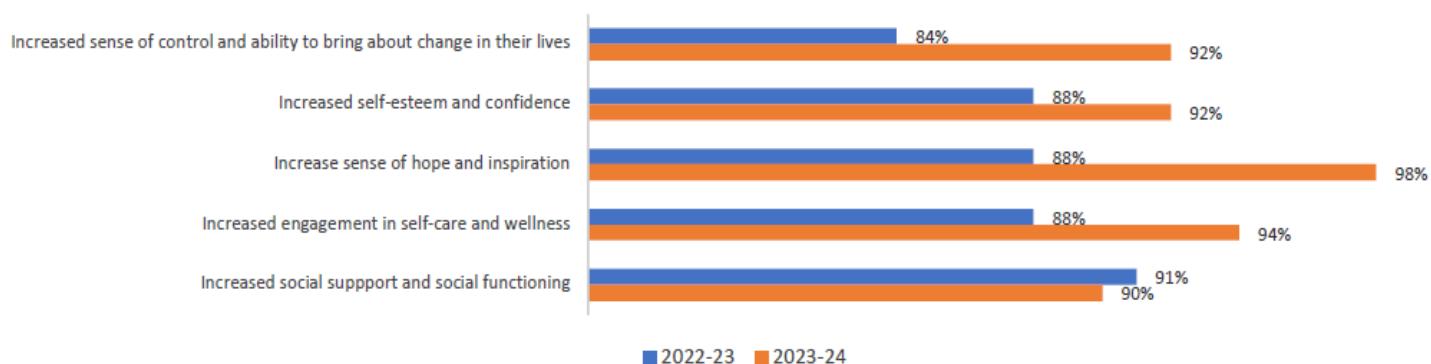


Program Evaluation and Outcomes

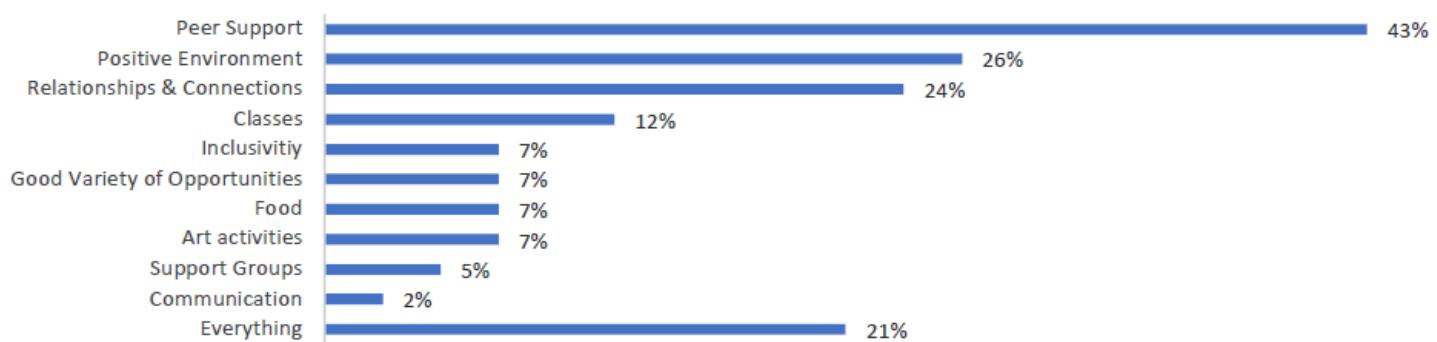
ICC's evaluation framework follows the SAMHSA Mental Health Recovery Model and tracks participant progress across five key areas: sense of control, self-esteem, hope, social support, and engagement in self-care. The evaluation combines attendance data, participant surveys, peer coaching records, and feedback loops to measure the program's impact and guide ongoing improvements.

Results from FY 23–24 demonstrated strong and consistent recovery outcomes among participants. All survey respondents (100%) reported progress in at least one recovery indicator, and 98% said that ICC made an extreme or large positive difference in their lives. The majority of participants (93%) identified something they learned through ICC that they planned to apply in their daily life, and 86% reported making positive behavioral or lifestyle changes as a result of participation. Participant satisfaction remained exceptionally high, with 96% feeling welcome and supported, 91% reporting that staff consistently treated them with respect, and 98% indicating that they would recommend ICC to a peer or friend.

ICC Participants Progress Towards Recovery Indicators



Peer staff invested more than 400 hours in the Medi-Cal Peer Support Specialist Certification Program, strengthening their professional skills and ensuring fidelity to trauma-informed and recovery-oriented practices. Collectively, these results illustrate ICC's success in promoting emotional wellness, connection, and empowerment through a peer-driven and culturally responsive model of care. ICC Program Strengths - Participant Feedback



Challenges and Adaptations

While ICC achieved strong growth and participant satisfaction, feedback identified two main improvement areas: expanded bilingual programming for Spanish-speaking participants and increased accessibility through evening, weekend, or hybrid programming.

In response, ICC hired an additional Spanish-speaking Peer Mentor to expand outreach and language access, added new peer-led mindfulness and movement classes, and developed an “Age & Wisdom” wellness group tailored to older adults. The Center also enhanced outdoor spaces for gatherings, introduced adaptive tools such as meditation cushions and yoga mats, and began exploring virtual programming for homebound and transportation-limited participants. Additionally, a Volunteer Leadership Group was formed to co-develop program activities and support community engagement efforts. These adaptations reflect ICC’s ongoing commitment to equity, accessibility, and participant-led service delivery.

CSS Outreach and Engagement – Project Access Program:

ParentsCAN (PCAN) Latino/a/x Outreach

Program Description

ParentsCAN (PCAN) provides culturally responsive one-on-one and group outreach to Latino/a/x families and individuals to identify needs and connect them to programs, supports, and community resources. Services include bilingual outreach at community events, school and agency presentations, and the distribution of resource materials and newsletters. The program helps families navigate developmental, behavioral health, and educational systems by offering trusted, accessible, and linguistically appropriate guidance. Through these activities, PCAN promotes early access to information, education, and community support for families who may otherwise face barriers to engagement.

During Fiscal Year 23–24, PCAN reached an estimated 8,000 to 10,000 individuals through in-person events, newsletters, and other outreach efforts. While demographic data are difficult to capture in large-scale outreach, PCAN continues to prioritize reaching underserved Latino/a/x communities throughout Napa County.

Target Population

The program primarily serves Latino/a/x parents, caregivers, and families of children and youth with developmental, behavioral, or mental-health needs. Many participants are unserved or underserved families who encounter barriers to accessing behavioral health or special education services. ParentsCAN focuses on providing culturally and linguistically responsive engagement opportunities that help families navigate complex systems, advocate for their children, and build stronger connections with schools and community-based providers.

Key Activities & Services

Throughout FY 23–24, ParentsCAN implemented a wide range of outreach and engagement activities across Napa County. Staff participated in 31 community events, including back-to-school nights, community health fairs, and school-based presentations at locations such as McPherson Elementary, Cope, and Camille Creek. Staff also collaborated with agencies such as HHSA Child Welfare Services (CWS) and Behavioral Health to strengthen community linkages. Collectively, these events reached more than 10,000 duplicated participants during the fiscal year.

ParentsCAN continued its strong communication strategy through e-newsletters and social media outreach. Ten e-newsletters and one printed newsletter were distributed during the year, covering topics such as inclusive classrooms, Autism Acceptance Month, summer activities for children with special needs, new developmental playgroups, and the annual Parent Conference announcement. Circulation ranged from 1,096 to 2,739 recipients per issue, resulting in over 13,000 total impressions. Social media engagement remained steady, with 168 posts shared across Facebook and Instagram, reaching an average of 152 to 208 individuals per post and peaking at nearly 1,000 viewers for high-interest content.

The Parents of Children with Challenging Behaviors Support Group continued to provide a vital space for parents to connect and learn. Offered virtually in Spanish, the group explored topics including suicide prevention, bullying, social media awareness, stress management, and parenting strategies from the Positive Parenting Program (Triple P). Following a transition in facilitators in late summer 2023, the group resumed regular meetings in early 2024 and featured guest speakers such as ADHD/ADD specialist Hilda Gutiérrez. Over the course of the fiscal year, the group served 36 duplicated participants.

ParentsCAN also administered respite services to support caregivers managing high levels of stress. During FY 23–24, the program received 14 respite requests totaling \$2,800 and distributed \$2,000 in direct support to families. These funds provided essential relief for parents and caregivers balancing intensive family care demands with limited access to formal respite services.

Outcome Highlights

In FY 23–24, ParentsCAN successfully expanded its outreach and strengthened its role as a trusted community resource for Latino/a/x families. The program connected with over 20,000 duplicated individuals through outreach, newsletters, and virtual activities, ensuring broad access to information and support. Its bilingual newsletters and social media campaigns significantly increased awareness of behavioral health services, special education supports, and parenting resources across the county. Families reported increased confidence in navigating service systems and greater awareness of available community programs.

Additionally, PCAN launched its YouthCAN project, designed to empower youth ages 18 to 25 with disabilities to strengthen self-advocacy skills and awareness of available supports. By combining outreach, education, and parent-led engagement, ParentsCAN continues to reduce

stigma, promote inclusion, and advance equitable access to early intervention and family-centered behavioral health supports in Napa County.

Challenges & Adaptations

During the reporting period, ParentsCAN experienced several transitions that required program adaptation. A change in support group facilitation during summer 2023 temporarily paused group sessions until a new facilitator began in January 2024. In addition, PCAN underwent an office relocation in spring 2024, which briefly reduced outreach scheduling and required logistical adjustments to resume in-person services. Despite these challenges, PCAN maintained steady engagement through virtual platforms and community partnerships.

The ongoing need for culturally specific, bilingual parent education and system navigation remains significant, underscoring the importance of maintaining flexible, accessible outreach strategies. ParentsCAN's commitment to cultural humility, collaboration, and family-driven services continues to guide its efforts to reach and empower the Latino/a/x community in Napa County.

Co-Occurring Disorders

Through a collaboration with the Behavioral Health Division's Substance Use Treatment Services, MHSA funds are used to provide support group services to individuals who have been diagnosed with a mental illness and a co-occurring substance abuse addiction. In FY 23-24, ADS staff served a total of 38 unduplicated individuals.

In addition, a realtor was engaged to identify potential sites for a new Behavioral Health Treatment Services facility designed to serve individuals with co-occurring mental health and substance use disorders. This effort supports Napa County's broader goal of expanding access to integrated treatment and recovery services for residents with dual diagnoses.

Community Services and Supports - System Development

Napa County's Community Services and Supports (CSS) System Development efforts focus on building and strengthening the County's behavioral health infrastructure to ensure a coordinated, accessible, and recovery-oriented system of care. System Development initiatives enhance service delivery capacity, improve crisis response, and promote collaboration among County departments, community-based organizations, and partner agencies.

These initiatives align with the intent of the Mental Health Services Act (MHSA) to ensure a continuum of care that is equitable, data-driven, and responsive to community needs. System Development funding supports programs that enhance the behavioral health system's ability to serve residents effectively, improve access to crisis intervention, and expand culturally responsive, community-based care.

One key initiative under this category is the CSS System Development Program: Mobile Response Team (MRT).

CSS System Development Program: Mobile Response Team (MRT)

Target Population:

Children, youth, adults, and older adults in Napa County who are experiencing behavioral health crises. MRT serves all individuals regardless of insurance status, age, or location within the county. The program is designed to provide timely, professional intervention that prioritizes safety, stabilization, and linkage to appropriate levels of care.

Program Description and Goals:

The Behavioral Health Mobile Response Team (MRT) provides same-day, in-person crisis intervention and support for individuals experiencing acute behavioral health crises. The program aims to prevent unnecessary hospitalization, reduce law enforcement involvement in behavioral health emergencies, and promote stabilization within the community whenever safely possible.

Launched on February 14, 2022, MRT initially operated Monday through Friday from 8:00 a.m. to 5:00 p.m. As part of the CalAIM Mobile Crisis Services Initiative, the program expanded on December 31, 2023, to provide 24-hour, seven-day-a-week coverage across Napa County.

The team consists of 4 licensed or registered mental health clinicians, 2 senior mental health workers, and a program supervisor, all trained in de-escalation, risk assessment, safety planning, and the initiation of involuntary psychiatric holds (5150) when appropriate. MRT also includes an Alcohol and Drug Services Counselor to ensure an integrated response for individuals whose crisis involves a substance use component.

The program's goals are to deliver rapid, trauma-informed crisis response; ensure equitable access to care; and connect individuals to follow-up behavioral health and community resources for continued support.

Key Activities and Services:

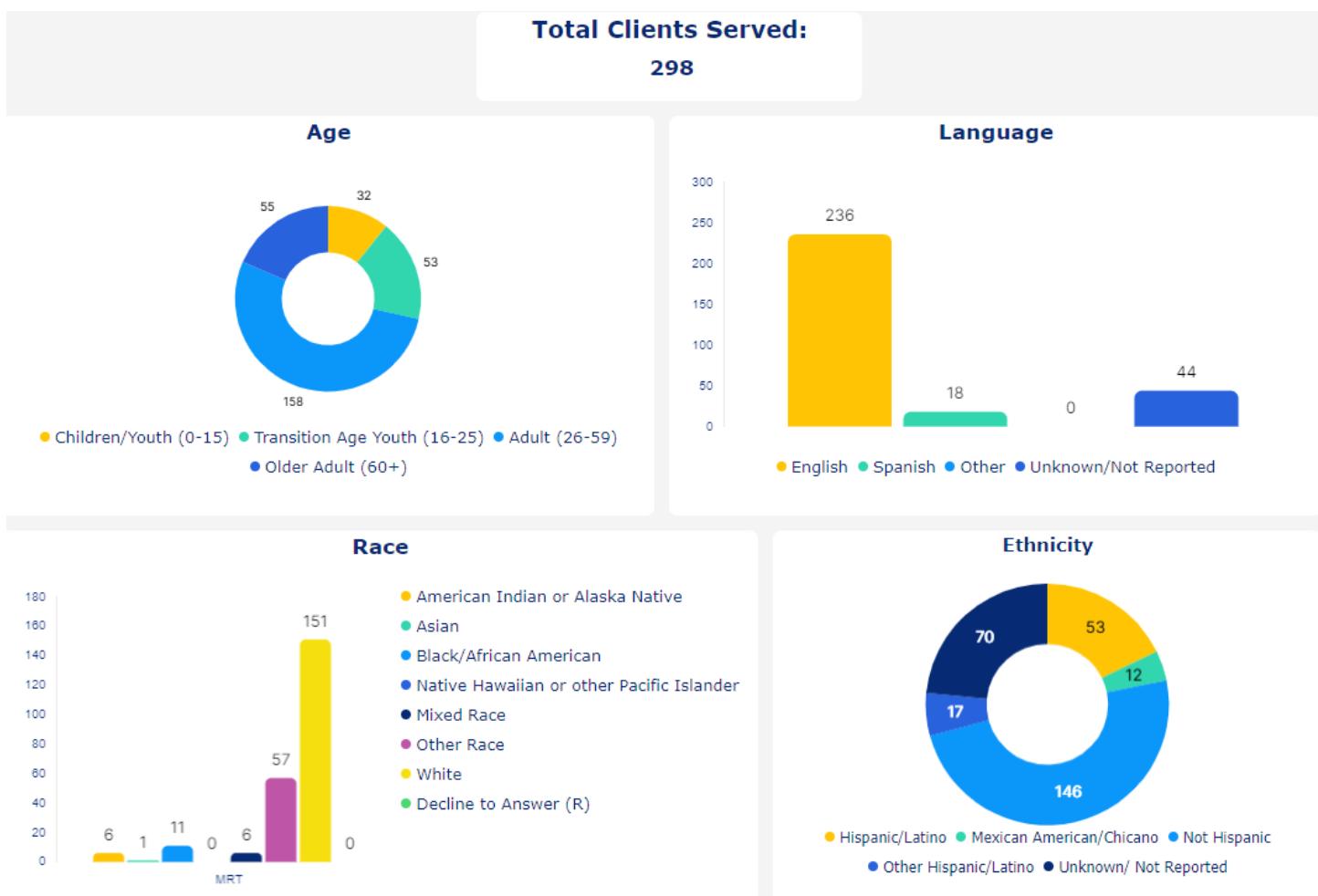
The Mobile Response Team responds to behavioral health crises that are reported through a dedicated community phone line. Calls are screened to assess safety, risk level, and appropriate response. Approximately 58% of calls are resolved through telephone support, which includes referrals, psychoeducation, and counseling. For the remaining calls, when an in-person response is deemed necessary, MRT deploys directly to the individual's location to provide immediate crisis assessment and intervention.

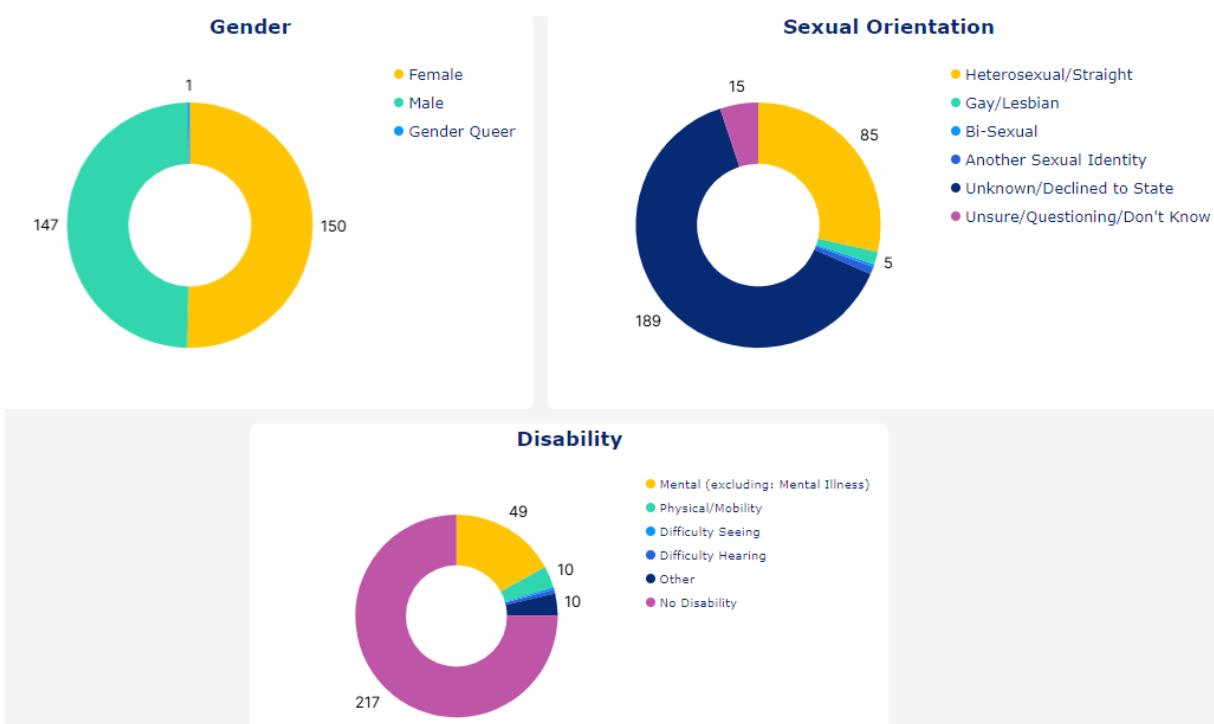
In-person responses are conducted by trained behavioral health professionals who prioritize de-escalation and stabilization within the community setting. MRT clinicians collaborate with individuals and their support networks to create safety plans and link them to ongoing behavioral health services. When additional stabilization or supervision is required, MRT staff may initiate a

5150 involuntary hold and facilitate transport to the Crisis Stabilization Services Center for further evaluation.

Following each in-person intervention, the team conducts follow-up contacts within 72 hours to ensure that individuals are successfully connected to ongoing treatment and community supports. MRT also collaborates closely with law enforcement, emergency medical services, and community partners to promote coordinated responses and minimize reliance on emergency departments.

Client Demographics





Estimated individuals served and cost per client:

MRT

Age Group	FY 23-24 Individuals Served	FY 24-25 Projected Individuals Served	FY 25-26 Projected Individuals Served
0-15 Children/Youth	32	60	80
16-25 TAY	53	100	135
26-59 Adult	158	216	290
60+ Older Adult	55	74	100
Total	298	450	605
Funding	\$1,001,876	\$1,574,854	\$2,365,018
Cost per client	\$3,362	\$3,499.68	\$3,909.12

Outcome Highlights:

In FY 23–24, the Mobile Response Team received 616 calls to the mobile response line. Of these, 258 calls (42%) required an in-person response, while the remaining 358 calls (58%) were effectively managed through phone-based support, referral, and crisis counseling.

Among the in-person responses, the following outcomes were recorded:

- **De-escalated on-site/stabilized in the community:** 167

- **5150/5585 holds initiated:** 43
- **Transported to Crisis Services:** 15
- **Law enforcement intervention:** 3
- **Other dispositions:** 9
- **Unresolved cases:** 21

The data indicate that most crises were resolved safely in the community without the need for hospitalization or law enforcement involvement, reflecting MRT's success in achieving its goal of community-based stabilization.

MRT responded to crises across a wide range of settings, demonstrating flexibility and accessibility:

- **Home:** 68
- **Community partner offices:** 32
- **Schools:** 40
- **Shelters:** 17
- **Health and Human Services Agency (HHSA):** 32
- **Street outreach/intervention:** 24
- **Other locations:** 45

These outcomes reflect the program's broad reach and commitment to meeting individuals where they are. MRT's integrated approach—combining mental health and substance use expertise—ensured comprehensive, person-centered interventions that addressed both immediate safety and long-term wellness. The expansion to **24/7 operations** significantly increased accessibility, allowing residents to receive crisis intervention services at any time of day or night.

Challenges and Adaptations:

During FY 23–24, MRT navigated challenges related to staffing capacity, increased call volume, and the complexities of coordinating responses across diverse geographic areas of the county. Expanding to 24/7 operations required recruitment, training, and logistical adjustments to ensure consistent coverage and team safety during overnight hours.

To address these challenges, MRT enhanced collaboration with community partners, including law enforcement, emergency medical services, and local hospitals, to strengthen referral pathways and response coordination. Staff also participated in advanced training focused on trauma-informed de-escalation and field safety. Continued investment in workforce development and interagency partnerships remains a key focus for sustaining program effectiveness and responsiveness to community needs.

Project Access Outreach and Engagement Programs estimated cost per duplicated individual:

Total Duplicated Individuals Served by Project Access in FY 23-24	11,066
Project Access Funding	\$524,361
Cost Per Duplicated Individual	\$47.38
Estimated Number of Individuals Served by Project Access Programs in FY 24-25	20,000
Projected Duplicated Number of Individuals Served to be served by Project Access Programs in FY 25-26	20,000

Community Services and Supports (CSS) Housing

Hartle Court Permanent Supportive Housing

Overview

Hartle Court, operated by Progress Foundation, provides 18 MHSA-funded permanent supportive housing units for adults with serious mental illness who are homeless or at risk of homelessness, alongside 6 non-MHSA units. All 18 MHSA units are restricted at 50 percent of Area Median Income (AMI) under a regulatory agreement with the California Housing Finance Agency (CalHFA) and were fully occupied as of June 30, 2025.

Resident Profile (FY 24–25)

The 20 residents included 16 adults ages 18–64 and 4 older adults ages 65 and above. Sixteen residents identified as living with a mental disability and three with both mental and physical disabilities. Demographically, 16 residents identified as White, 2 as American Indian/Alaska Native, 1 as Hispanic/Latino, and 1 as Native Hawaiian/Pacific Islander. Household incomes ranged primarily from \$10,001 to \$15,000 annually, with typical rents between \$251 and \$300 per month. Every resident was homeless at initial rent-up, and as of this reporting period no grievances or complaints were filed.

Supportive Services

Residents continue to have access to on- and off-site supportive services provided by Progress Foundation and Napa County HHSA Behavioral Health, including service coordination, case management and crisis intervention, substance use services, medication education, life-skills training, benefits navigation, employment and peer support, tenant councils, AA/NA groups, linkages to primary care, and domestic-violence resources.

Capital and Sustainability Update (FY 25–26)

To ensure the long-term sustainability of Hartle Court, Napa County HHSA Behavioral Health allocated \$1,264,000 to augment the project's Capitalized Operating Subsidy Reserve (COSR) managed by CalHFA. While this allocation was approved and set aside in FY 23–24, as of the drafting of this report the County is still awaiting CalHFA's execution of the COSR contract. The Division continues active coordination with CalHFA and Progress Foundation and anticipates execution before the end of calendar year 2025. Once finalized, the COSR funds will stabilize long-term operating costs and preserve affordability for residents.

Looking Ahead

In FY 25–26, Napa County HHSA Behavioral Health will continue to partner with CalHFA, Progress Foundation, and the County Housing Division to ensure ongoing compliance with MHSA housing requirements and to identify new permanent supportive housing opportunities for behavioral health clients through BHSA and state capital initiatives.

Prevention and Early Intervention (PEI)

Component Overview

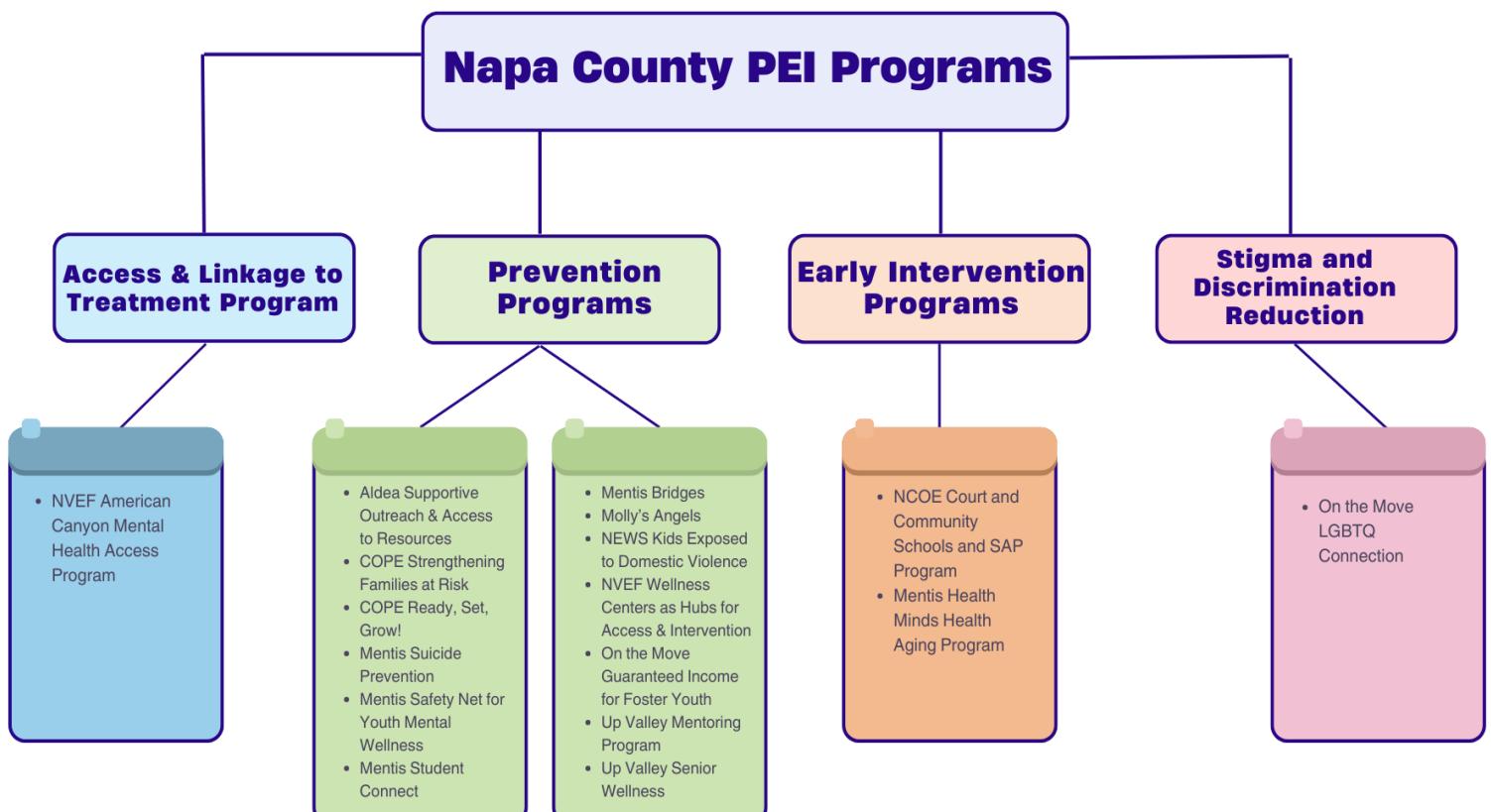
The Prevention and Early Intervention (PEI) component of the Mental Health Services Act (MHSA) is designed to reduce the onset and long-term impacts of untreated mental illness by intervening early and reinforcing protective factors. Napa County's PEI programs are centered on four core goals: increasing awareness of mental health needs, reducing stigma and discrimination, preventing suicide, and connecting individuals to appropriate services before mental health conditions become severe or disabling.

In accordance with state requirements, more than 50% of PEI funding is allocated to serve children, youth, and transition-age youth. This investment ensures that support is provided during critical stages of development when early intervention is most effective in changing long-term outcomes.

Napa County is committed to increasing timely access to services for unserved and underserved populations by offering programs that are culturally responsive, community-based, and accessible in trusted settings. These programs are grounded in evidence-based, promising, and community-defined practices, aligning with Napa County Health and Human Services' broader goals of promoting health equity and inclusion. This integrated approach ensures that prevention and early intervention services are not only clinically effective but also accessible and meaningful to those most in need. To strengthen equity and responsiveness, programs are funded within specific categories that directly address the needs of identified unserved and underserved populations.

Napa County PEI Programs

Napa County implements a diverse array of Prevention and Early Intervention (PEI) programs that reflect a comprehensive, community-centered approach to mental health. These programs are organized across key focus areas: Access and Linkage to Treatment, Prevention, Early Intervention, and Stigma and Discrimination Reduction. Together, they exemplify the county's commitment to early action and long-term wellness. The following section provides detailed descriptions of each PEI program by focus area.



Access and Linkage to Treatment

In the area of access and linkage to treatment, the **Napa Valley Education Foundation (NVEF) American Canyon Mental Health Access Program** plays a critical role in identifying individuals with emerging mental health needs and connecting them to timely, appropriate care. This program is instrumental in reducing delays in treatment, particularly for youth and families in underserved areas.

Access and Linkage to Treatment Program Name:

Napa Valley Education Foundation (NVEF) American Canyon Mental Health Access

Target Population

The American Canyon Mental Health Access Program (ACMHA) serves youth in American Canyon, a historically underserved community within the Napa Valley Unified School District (NVUSD). The program focuses on students who show early signs of emotional or behavioral challenges such as anxiety, depression, and social-emotional difficulties. ACMHA targets elementary and

middle-school youth and aims to reduce disparities in access to school-based behavioral-health supports for low-income and racially diverse students.

Program Description and Goals

The ACMHA Program provides school-based prevention and early-intervention services through a comprehensive model that aligns with the Multi-Tiered System of Support (MTSS) framework and the guiding principle that *“all means all.”* The approach ensures that every student has access to screening, prevention, and intervention supports appropriate to their level of need.

Key goals include:

- Promoting overall student wellness and resilience.
- Identifying emerging behavioral-health needs early.
- Providing timely access to mental-health care within school settings.
- Strengthening staff capacity to recognize and respond to social-emotional needs.
- Building partnerships among schools, families, and community providers to ensure continuity of care.

Key Activities and Services

The ACMHA Program employs licensed social workers, school psychologists, and counselors who deliver interventions across three tiers of MTSS:

- **Tier 1 – Universal Prevention:** School-wide supports for all students, including behavioral-health screening using the Strengths and Difficulties Questionnaire (SDQ), Positive Behavioral Interventions and Supports (PBIS), restorative practices, and social-emotional-learning activities.
- **Tier 2 – Strategic Prevention:** Small-group interventions for students needing additional support, such as group counseling, “Bounce Back” resiliency groups, and mentoring.
- **Tier 3 – Intensive Intervention:** Individualized services for students with higher-level needs, including one-on-one counseling, intensive case management, behavioral-support plans, and linkage to community-based behavioral-health services.

This tiered structure ensures that students receive the right level of care at the right time, helping them feel safe, supported, and engaged in learning.

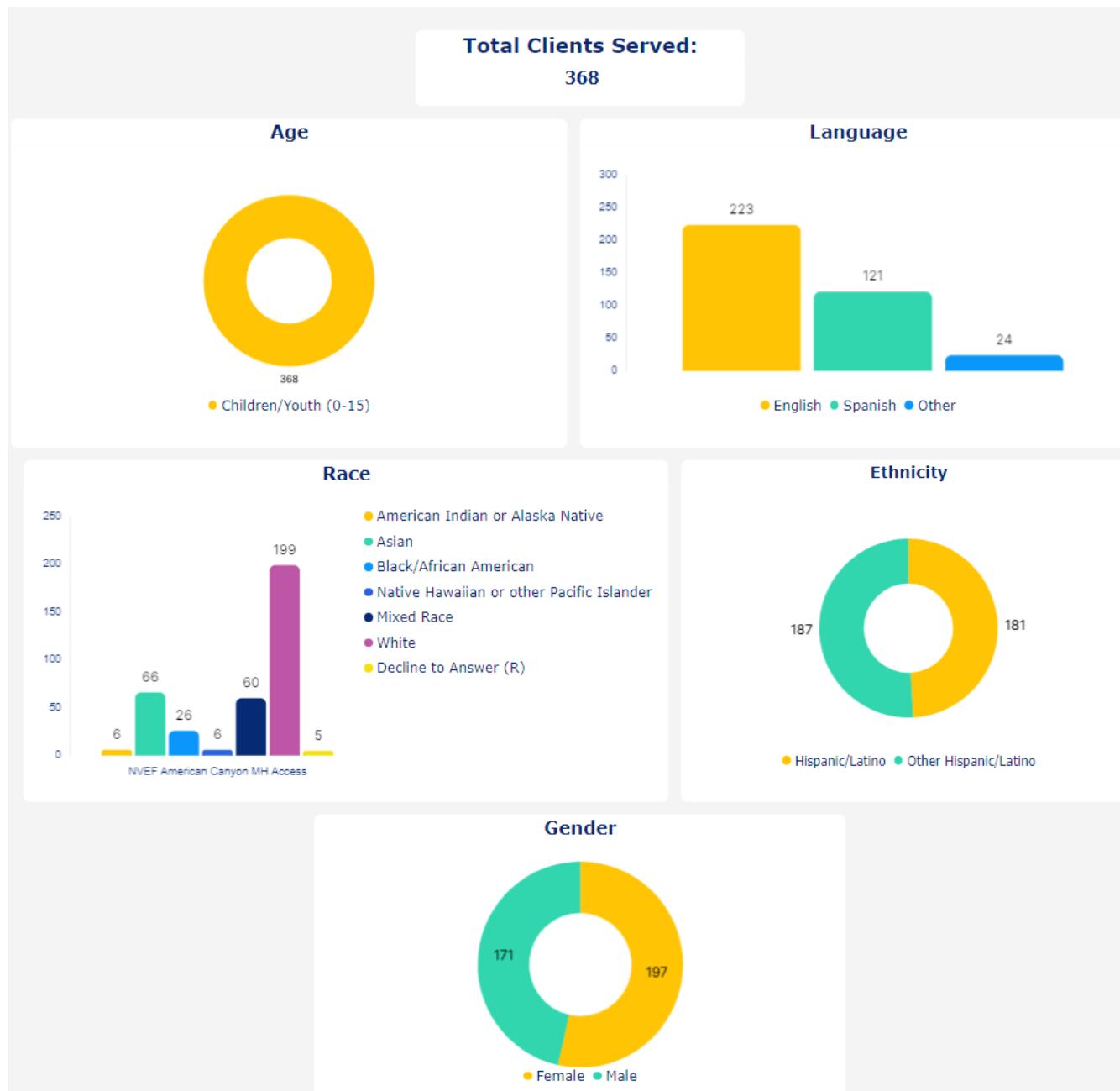
Client Demographics and Service Volumes (FY 23–24)

During FY 23–24, ACMHA provided behavioral-health screening and support to 1,036 students at American Canyon Middle School. Based on screening results and referrals from teachers and families, 368 students received targeted behavioral-health services.

- **245 students** received brief one-on-one interventions.

- **59 students** engaged in ongoing case management.
- **21 students** received crisis assessments.
- Approximately **80 %** of students benefited from Tier 1 universal-prevention activities, **10–15 %** participated in Tier 2 small-group prevention, and 3–5 % received Tier 3 individualized interventions. Four counseling groups—SUDS, Anxiety, Family (Divorce), and Mariposa—were held with attendance ranging from 2 to 7 students per session.

Demographics:



Estimated individuals served and cost per client:

Age	FY 23-24 Individuals Served	FY 24-25 Projected Individuals Served	FY 25-26 Projected Individuals Served
0-15 Children/Youth	368	474	474
16-25 TAY			
26-59 Adult			
60+ Older Adult			
Total	368	474	474
Contract amount	\$139,000	\$310,359	\$310,359
Cost per client	\$377.72	\$654.77	\$654.77

Outcome Highlights

The ACMHA Program successfully implemented the MTSS framework across all levels of prevention and intervention. The universal SDQ screening allowed for early identification of behavioral-health needs, ensuring students received timely support. Students participating in Tier 2 and Tier 3 interventions demonstrated improved emotional regulation, coping skills, and school engagement. Teachers and families reported noticeable improvements in communication and problem-solving among participating students.

Professional-development activities strengthened staff capacity: teachers and school personnel received training in trauma-informed and culturally responsive practices, increasing their confidence in identifying and referring students with social-emotional needs. The integration of schoolwide PBIS and SEL practices also contributed to improved campus climate and reduced behavioral incidents.

Challenges and Adaptations

The program faced challenges related to inconsistent student attendance, which occasionally affected participation in group sessions and continuity of care. Staff also noted an increase in the complexity of student mental-health needs, requiring more time-intensive interventions and coordination with community providers.

To address these challenges, ACMHA adapted service delivery by increasing coordination between school staff and mental-health providers, offering make-up sessions for absent students, and expanding staff wellness initiatives to support those managing higher caseloads. Ongoing professional development and partnership with community-based agencies continue to strengthen program sustainability and effectiveness.

Prevention Programs

Napa County's prevention programs aim to build resilience and reduce risk factors before mental health challenges escalate. These programs include **Aldea's Supportive Outreach and Access to Resources**, which focuses on early engagement and system navigation, and **COPE's Strengthening Families at Risk and Ready Set Grow!**, both of which support family functioning and positive child development. **Mentis**, a key mental health provider in the region, offers several prevention-focused initiatives including **Suicide Prevention**, **Safety Net for Youth Mental Wellness**, **Student Connect**, and **Bridges Community Mental Health Treatment**, all designed to provide youth-centered support in school and community settings.

Additional programs such as the **Molly's Angels Program for Older Adults**, **NEWS Kids Exposed to Domestic Violence**, and **Up Valley Senior Wellness Program** address the needs of vulnerable populations, including older adults and children impacted by trauma. Programs like the **NVEF Wellness Centers**, which serve as trusted hubs for care and intervention in school settings, and **On The Move's Guaranteed Income for Foster Youth**, which addresses economic instability among transition-age youth, further expand the reach and impact of prevention efforts. The **Up Valley Mentoring Program (CLARO/A)** also provides culturally grounded mentorship and support for Latinx youth in rural areas. Each program will be described in detail following.

Prevention Program Name:

Aldea Supportive Outreach & Access to Resources (SOAR)

Target Population

The SOAR program serves youth and young adults ages 8 to 30 who have experienced a first episode of psychosis (FEP) within the past two years. Participants may present with schizophrenia spectrum disorders, schizoaffective disorder, schizopreniform disorder, or mood disorders with psychotic features.

Psychosis frequently co-occurs with substance use, and national research indicates that approximately 40 percent of individuals with psychosis develop a substance-use disorder—more than double the rate in the general population. Accordingly, SOAR maintains close coordination with substance-use-treatment providers to ensure comprehensive, integrated care that addresses both mental health and co-occurring needs.

Program Description and Goals

The Aldea Supportive Outreach & Access to Resources (SOAR) program delivers early-intervention services to young people experiencing a first episode of psychosis. Guided by the UC Davis Early Psychosis Intervention model, SOAR employs a Coordinated Specialty Care (CSC)

approach—an evidence-based, multi-disciplinary model emphasizing early access, individualized treatment planning, and strong family involvement.

The program's goals are to:

- Provide timely intervention to reduce the long-term impact of psychosis and improve recovery outcomes.
- Deliver individualized, evidence-based treatment addressing clinical, social, educational, and vocational needs.
- Support family engagement and empowerment through education and collaboration.
- Promote functional recovery, independence, and community connection.

Participants typically engage in SOAR for up to two years, receiving comprehensive and family-centered services designed to stabilize symptoms, improve quality of life, and foster lasting recovery.

Key Activities and Services

SOAR offers a comprehensive continuum of coordinated services designed to promote symptom reduction, functional recovery, and family empowerment. Each participant begins with a thorough clinical assessment and diagnostic evaluation to guide individualized treatment. Psychiatric providers offer ongoing medication management, and participants engage in Cognitive Behavioral Therapy for Psychosis, an evidence-based modality that helps reduce distress associated with psychotic symptoms and build practical coping skills.

Family engagement is central to SOAR's success. Through Multi-Family Group Treatment, families receive psychoeducation about psychosis, learn collaborative problem-solving strategies, and expand their social support networks. A Family Partner, a peer professional with lived experience, provides family advocacy, models recovery-focused approaches, and strengthens natural supports.

Beyond clinical and family services, SOAR integrates education, and employment supports to promote recovery and independence. Participants receive individualized assistance in pursuing academic or vocational goals, building job skills, and accessing financial and community resources. Together, these supports address both the clinical and social dimensions of wellness, enabling participants to achieve stability and meaningful community participation.

Client Demographics and Service Volumes (FY 23–24)

During FY 23–24, SOAR enrolled 13 participants, surpassing the annual target of 9. Participants ranged in age from 8 to 25 years, with a majority identifying as Latino or White, reflecting the demographics of Napa County's transition-age-youth and young-adult population.

Estimated individuals served and cost per client:

Age	FY 23-24 Individuals Served	FY 24-25 Program shifted to CSS Funding	FY 25-26 Program shifted to CSS Funding
0-15 Children/Youth	8		
16-25 TAY	5		
26-59 Adults	0		
60+ Older Adults	0		
Other individuals served outreach and engagement	223		
Total	236		
Contract amount	\$234,238		
Cost per client	\$992.53		

Outcome Highlights

Mid-year FY 23–24 results demonstrate significant progress toward key outcome measures. Ninety-two percent of participants did not experience psychiatric hospitalization while enrolled in the program, reflecting effective stabilization and early intervention. Among the three participants who were discharged during the reporting period, 100 percent avoided psychiatric hospitalization within 320 days post-discharge—exceeding the program’s 85 percent target. Additionally, all discharged clients received education, employment, and referral supports prior to program completion, fully meeting the 75 percent goal.

The program utilizes the Compass 10 assessment to evaluate symptom reduction and functional improvement every six months. Of the clients reassessed mid-year, two of three demonstrated improvements in the six months, and one participant reassessed in the twelve months showed continued progress. These outcomes illustrate the program’s effectiveness in fostering stability, preventing hospitalization, and promoting educational and vocational success among young people experiencing early psychosis.

Challenges and Adaptations

While results indicate strong performance, several challenges persist. Early identification and timely referrals remain ongoing barriers, as youth and families may delay seeking treatment due to stigma, lack of awareness, or uncertainty about symptoms. Recruitment and retention of clinicians trained in early-psychosis intervention have also been challenging, given the specialized skills required. Furthermore, housing instability and transportation barriers can limit consistent participation for some clients.

To address these challenges, Aldea expanded outreach and education efforts with schools, primary-care providers, and community partners to increase early detection and improve referral

pathways. The program also implemented telehealth and hybrid service options to enhance flexibility and continuity of care. Strengthened partnerships with Napa County Behavioral Health and local substance-use programs further support the integration of services and provide participants with comprehensive wraparound care.

Prevention Program Name:

Cope Family Resource Center – Strengthening Families at Risk (SFAR) Program

Target Population

The Strengthening Families at Risk (SFAR) program serves parents and caregivers in Napa County who are at risk of developing mental health challenges such as depression, anxiety, post-traumatic stress disorder (PTSD), or other mental health-related conditions. The program prioritizes families facing significant life stressors that can undermine parenting capacity, strain relationships, and impact child well-being. SFAR specifically focuses on caregivers who may not yet meet the criteria for mental health treatment but would benefit from early intervention to prevent symptom escalation and strengthen family functioning. The program's approach centers on prevention, resilience, and family empowerment, with an emphasis on reducing the intergenerational impact of stress and trauma.

Program Description and Goals

The Strengthening Families at Risk (SFAR) program aims to reduce the risk factors associated with the onset of mental illness through early identification, parent education, and connection to supportive resources. Grounded in research demonstrating that children thrive when parents have the emotional and practical tools to manage stress and maintain healthy relationships, SFAR enhances protective factors by helping caregivers build self-awareness, improve emotional regulation, and apply positive parenting strategies.

The program's goals are to:

- Increase parental resilience and coping skills to prevent the escalation of stress-related symptoms.
- Strengthen parent-child relationships and improve overall family functioning.
- Promote early identification of emerging behavioral health needs through screening and outreach.
- Connect caregivers to community-based supports and behavioral health services as needed.
- Enhance protective factors that reduce the risk of mental health challenges in both parents and children.

- Foster stable, nurturing family environments that support children's healthy emotional development.

Key Activities and Services

SFAR delivers a continuum of prevention and early intervention services that combine outreach, screening, education, and evidence-based parenting programs. Parents entering the program receive initial screenings conducted by Cope Resource Specialists using conversational screening questions to identify potential concerns. For caregivers participating in Triple P Level 4 or Level 5 services, staff utilize standardized tools such as the Strengths and Difficulties Questionnaire (SDQ) and the Depression, Anxiety, and Stress Scales (DASS-21) to assess behavioral health needs and tailor interventions.

Based on screening results, parents receive individualized or group-based Triple P Standard or Triple P Transitions sessions. These evidence-based interventions help caregivers enhance parenting skills, reduce stress, and strengthen the parent-child relationship. Participants demonstrating emerging or active mental health needs are referred to county behavioral health or community-based providers for additional care. Through this coordinated approach, SFAR builds resilience and strengthens protective factors that reduce the risk of mental illness in both parents and children.

Client Demographics and Service Volumes (FY 23–24)

During FY 23–24, a total of 17 individuals were directly served through SFAR's Triple P services. The majority were adults ages 26–59 (13 participants), with 3 transition-age youth (16–25) and 1 child under age 15. Of those served, 76 percent identified as female and 24 percent as male. Participants represented diverse backgrounds: 65 percent identified as "Other Race," and 35 percent as White. The majority spoke Spanish (8 participants) or English (7 participants) as their preferred language, reflecting the program's bilingual service model.

Most participants identified as Mexican American/Chicano (8 participants) or other Hispanic/Latino (1 participant), with the remainder reporting unknown or unreported ethnicity. Regarding sexual orientation, 82 percent identified as heterosexual, and 18 percent declined to state. Ten participants reported no disability, while six declined to answer and one reported multiple disabilities (mental, physical/mobility, chronic health condition, or other). The total contract amount for FY 23–24 was \$98,000, resulting in a cost per client of \$5,764.71.

Estimated individuals served and cost per client:

Age	FY 23-24 Individuals Served	FY 24-25 Projected Individuals Served	FY 25-26 Projected Individuals Served
0-15 Children/Youth	1	1	1
16-25 TAY	3	3	3
26-59 Adult	13	13	13
60+ Older Adult	0	0	0
Total	17	17	17
Contract amount	\$90,000	\$90,000	\$90,000
Cost per client	\$5,294	\$5,294	\$5,294

Outcome Highlights

During FY 23–24, the Strengthening Families at Risk Program demonstrated strong engagement and countywide reach. Between July and December, program staff participated in 15 outreach events attended by over 2,300 community members, raising awareness of parenting supports and mental health resources. The program received 80 referrals, conducted 118 screenings, and provided individual or group services to 131 participants through its combined service offerings.

Of the individuals served, 45 caregivers engaged in Triple P services and 55 participated in the Parents as Teachers (PAT) Home Visiting Program. These interventions helped parents improve emotional regulation, strengthen positive parenting practices, and expand social supports, all key protective factors that reduce the likelihood of future mental health crises. In addition, 22 parents were referred to county behavioral health services for higher-level care, demonstrating strong coordination across Napa County’s prevention and treatment continuum.

Overall, the SFAR program continues to effectively engage families at risk of mental health challenges by providing early, accessible, and culturally responsive supports that build resilience, reduce isolation, and strengthen family stability.

Challenges and Adaptations

During FY 23–24, the SFAR program faced several challenges related to participant engagement and the growing complexity of family needs. Some caregivers experienced limited availability due to work schedules or transportation barriers, which affected attendance in group sessions. Staff also observed increasing rates of stress and behavioral concerns among families linked to economic pressures and post-pandemic recovery challenges.

To adapt, Cope expanded its bilingual outreach efforts, offered more flexible scheduling and hybrid service options, and increased coordination with partner agencies to streamline referrals and follow-up. Staff also strengthened connections with Napa County Behavioral Health and other community providers to ensure warm hand-offs for families requiring higher-level

interventions. These adaptations helped sustain program accessibility and engagement despite ongoing environmental and socioeconomic challenges.

Prevention Program Name:

Cope Family Center – Ready, Set, Grow! (RSG!) Program

Target Population

The Ready, Set, Grow! (RSG!) Program serves families in Napa County with children ages 0 to 5. The program targets caregivers and young children who may experience developmental, behavioral, or emotional challenges and who would benefit from early identification and support. By focusing on families in the earliest stages of a child's life, RSG! aims to strengthen Napa County's early childhood prevention and intervention system, particularly among families experiencing barriers to care such as poverty, language, or limited access to specialized infant-parent mental health resources.

Program Description and Goals

The Ready, Set, Grow! (RSG!) Program is designed to strengthen Napa County's system of prevention and early intervention for families with young children by expanding access to screenings, improving service coordination, and increasing the availability of infant-parent mental health supports. Building on the work of the First 5 Napa Family Support and Home Visiting (FSHV) Collaborative's Infant-Parent Mental Health (IPMH) Support Project, the program leverages community partnerships and PEI funding to close service gaps for children and caregivers with emerging mental health or developmental concerns.

Program Goals:

- Increase early identification of developmental, behavioral, and mental health needs among young children and caregivers.
- Enhance provider capacity by expanding staff training and certification in standardized developmental screening tools (ASQ-3 and ASQ-SE2).
- Improve coordination of care between agencies serving families with young children to ensure seamless access to supports.
- Expand access to infant-parent mental health (IPMH) interventions and Triple P Level 4/5 parenting services.
- Strengthen family resilience through culturally responsive navigation, education, and resource connection.

Key Activities and Services

The Ready, Set, Grow! (RSG!) program expands countywide capacity to identify and respond to

developmental and behavioral health needs through a comprehensive set of activities that include training, system navigation, and direct family support. The program's cornerstone goal is to ensure consistency and quality in developmental screening across agencies by training staff in the Ages & Stages Questionnaire (ASQ-3) and Ages & Stages Social-Emotional Questionnaire (ASQ-SE2). During FY 23-24, 15 staff were targeted to complete certification, enhancing cross-agency alignment and data quality in early screening practices.

A key feature of RSG! is its dedicated System Navigator, who works directly with families to assess needs, coordinate referrals, and connect them to appropriate mental health and family support services. The Navigator collaborates with partner agencies through tools such as Unite Us, ensuring timely communication and smooth transitions between services. Families are supported throughout the process, with follow-up contacts that provide reassurance and assistance as new needs arise.

RSG! also expands access to infant-parent mental health interventions and parent coaching by integrating Home Visiting and Triple P Level 4/5 services. The program engages Infant-Parent Mental Health (IPMH) Fellows to provide family counseling and supports capacity-building within community partner agencies through financial and training assistance. Together, these efforts ensure that families of young children receive coordinated, accessible, and culturally responsive prevention and early intervention services.

Client Demographics and Service Volumes (FY 23-24)

During FY 23-24, the Ready, Set, Grow! (RSG!) program served 26 participants. Of these, 6 were children/youth (ages 0-15), 2 were transition-age youth (16-25), and 17 were adults (26-59). The majority of participants identified as female (21), with 3 male and 2 declining to state.

Most participants identified as Hispanic or Latino (19), while 7 did not report ethnicity. Participants were linguistically diverse: 12 spoke Spanish, 5 spoke English, 8 spoke other languages, and 1 declined to report. In terms of race, the largest group identified as Other Race (19), followed by White (2) and Mixed Race (1), with 4 unreported. The majority identified as heterosexual (16), and 10 declined to state or were unsure.

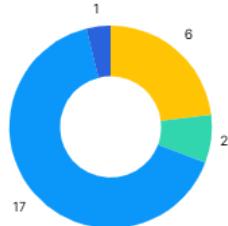
Three participants reported disabilities—two with mental or hearing impairments—and 21 reported no disability. The program's contract amount for FY 23-24 was \$120,000, resulting in a cost per client of \$4,615.38.

Demographics

Total Clients Served:

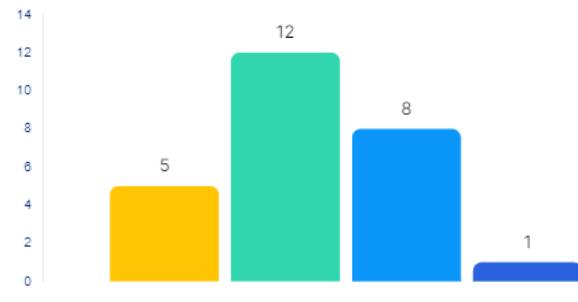
26

Age

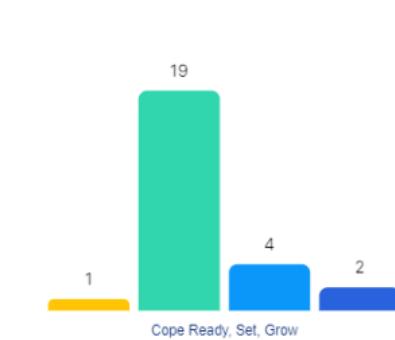


● Children/Youth (0-15) ● Transition Age Youth (16-25) ● Adult (26-59)
● Declined to Answer

Language



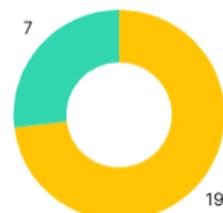
Race



Cope Ready, Set, Grow

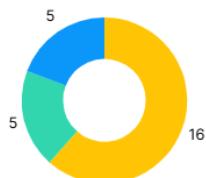
● Mixed Race
● Other Race
● Race Not Available/Unknown
● White

Ethnicity



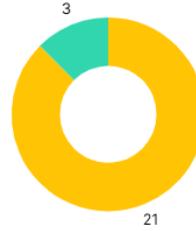
● Hispanic/Latino ● Unknown/ Not Reported

Sexual Orientation



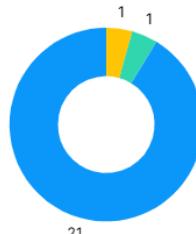
● Heterosexual/Straight ● Unknown/Declined to State
● Unsure/Questioning/Don't Know

Gender



● Female ● Male

Disability



● Mental (excluding: Mental Illness) ● Difficulty Hearing ● No Disability

Estimated individuals served and cost per client:

Age	FY 23-24 Individuals Served	FY 24-25 Projected Individuals Served	FY 25-26 Projected Individuals Served
0-15 Children/Youth	7	7	7
16-25 TAY	2	2	2
26-59 Adult	17	17	17
60+ Older Adult	0	0	0
Total	26	26	26
Contract amount	\$120,000	\$120,000	\$120,000
Cost per client	\$4,615.38	\$4,615.38	\$4,615.38

Outcome Highlights

During FY 23–24, the Ready, Set, Grow! (RSG!) program made measurable progress in enhancing early childhood mental health coordination and expanding access to family supports. The program received 32 referrals and conducted 22 developmental and behavioral screenings. RSG! facilitated six countywide trainings, reaching more than 50 service providers, including 21 who completed ASQ-3 and ASQ-SE2 certification. These trainings strengthened screening consistency, early identification practices, and interagency collaboration.

The program also successfully launched its System Navigator role in July 2023. The Navigator played a key role in connecting families to screenings, assessments, and resources, using the Unite Us platform to facilitate referrals and maintain collaboration among community partners. Families supported through the Navigator reported feeling better connected and supported, often returning for additional assistance as new challenges arose.

Additionally, RSG! strengthened cross-sector partnerships through participation in collaborative committees focused on Screening, Infant–Parent Mental Health (IPMH), System Navigation, and the RSG! Collaborative. These efforts collectively advanced countywide goals of coordination, early intervention, and equitable access to family mental health supports.

Challenges and Adaptations

While the Ready, Set, Grow! (RSG!) program achieved significant milestones, several challenges affected its full implementation. Many families required more intensive, long-term support than anticipated, limiting the number of families that could be served. Limited staffing capacity also constrained the number of screenings that could be completed, highlighting the need for additional System Navigators to meet the growing community demand.

Families' most immediate needs often related to basic necessities such as food, housing, and transportation. To address this, the System Navigator adapted by connecting families with emergency resources to stabilize their circumstances before focusing on mental health needs.

The program also experienced organizational changes, including leadership transitions among key partner agencies, which temporarily impacted collaboration and meeting attendance.

In response, RSG! prioritized strengthening existing tools rather than introducing new screening instruments. The Screening Committee expanded training and use of the ASQ-3 and ASQ-SE2 and implemented the Environmental Screening Questionnaire (ESQ) to identify families who would benefit from short-term case management. Despite these challenges, Ready, Set, Grow! continues to demonstrate adaptability, responsiveness, and leadership in supporting Napa County's youngest residents and their families.

Prevention Program Name:

Mentis Suicide Prevention

Target Population

The Mentis Suicide Prevention Program serves individuals across Napa County who are at risk for suicide, with a particular focus on adolescents, men, and seniors, as well as other populations experiencing social isolation or limited connection to mental health services. The program also engages community sectors and professionals who have frequent contact with vulnerable groups—such as educators, first responders, coaches, faith leaders, hospitality workers, and caregivers—to increase awareness and preparedness to intervene when someone may be in crisis. By strengthening community awareness and response capacity, the program ensures that suicide prevention is a shared responsibility across systems and communities.

Program Description and Goals

The Mentis Suicide Prevention Program is designed to reduce stigma, increase awareness, and strengthen the community's ability to recognize and respond to suicide risk. Through the leadership of the Napa County Suicide Prevention Council (SPC), coordinated outreach, and targeted training initiatives, the program equips individuals and organizations to intervene effectively and connect people in crisis to timely support.

Program Goals:

- Reduce stigma around suicide and mental illness through education, outreach, and public awareness campaigns.
- Increase access to mental health resources by providing individuals and organizations with knowledge of referral options and crisis supports.
- Expand the number of trained gatekeepers who can recognize suicide warning signs and connect at-risk individuals to care.
- Strengthen countywide coordination through the Suicide Prevention Council, ensuring a unified and strategic approach to suicide prevention.

- Promote a culture of resilience and connectedness across Napa County, where community members are empowered to take action to prevent suicide.

Key Activities and Services

The Mentis Suicide Prevention Program delivers a comprehensive, multi-layered approach to suicide prevention and awareness across Napa County. Program staff chair and facilitate the Napa County Suicide Prevention Council (SPC), which includes diverse community representatives from schools, health care, law enforcement, and community-based organizations. The SPC guides strategic planning and coordinates initiatives that expand the community's suicide prevention infrastructure.

A central component of the program is the delivery of Question, Persuade, Refer (QPR) trainings, an evidence-based suicide prevention curriculum that teaches individuals to recognize warning signs, engage in supportive dialogue, and connect people to professional help. Trainings are provided to youth, educators, first responders, hospitality workers, and other high-contact professionals. The program also conducts community outreach through public campaigns, presentations, and Wellness Café discussion groups, distributing printed materials, flyers, and social media content throughout schools, health centers, faith-based institutions, and workplaces.

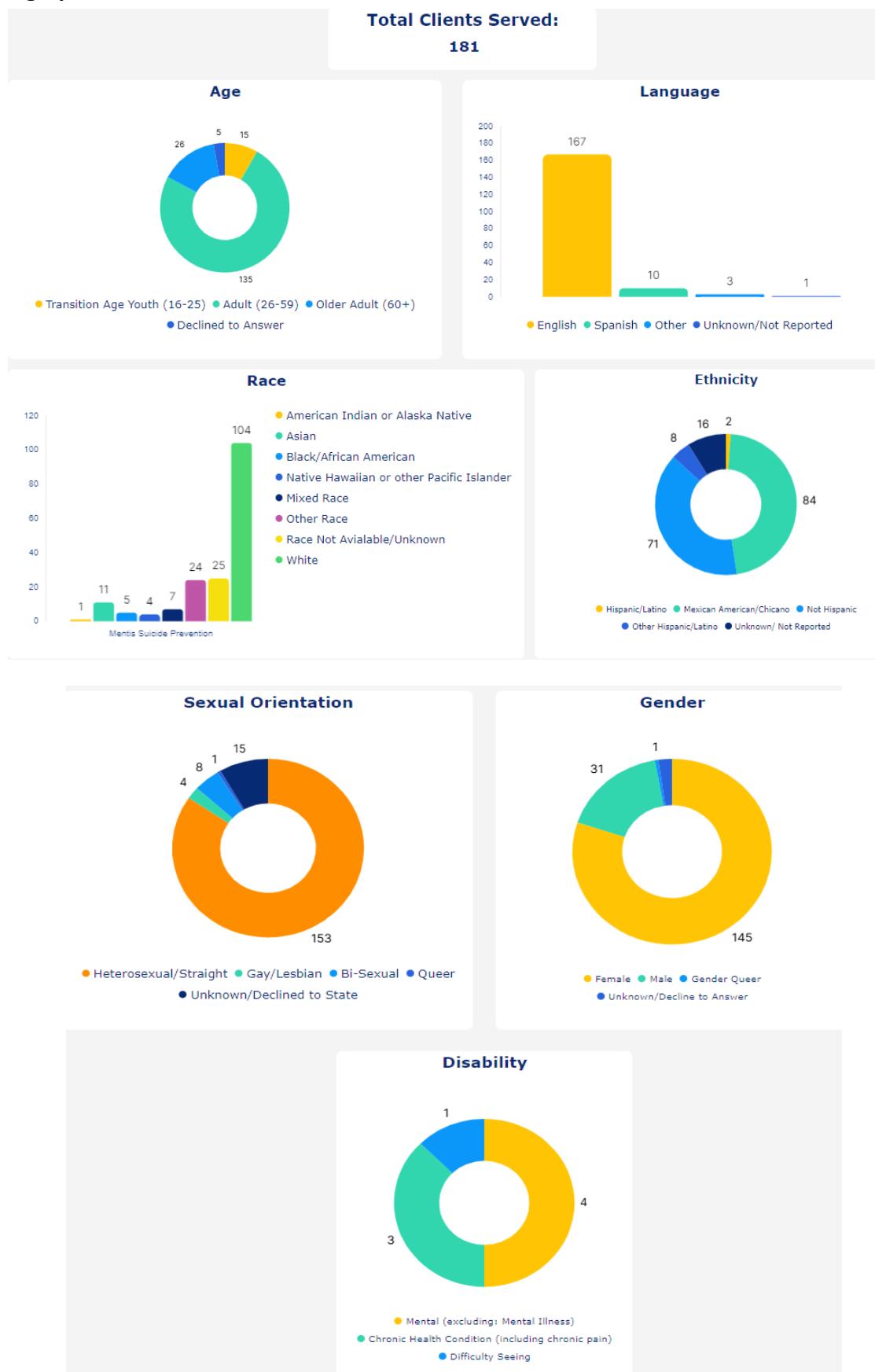
Together, these strategies build public awareness, reduce stigma, and empower community members to identify and support individuals at risk for suicide.

Client Demographics and Service Volumes (FY 23–24)

In FY 23–24, the Mentis Suicide Prevention Program served 181 participants. The majority were adults ages 26–59 (135 participants), with 15 transition-age youth (16–25), 26 older adults (60+), and 5 declining to report age. Participants represented diverse racial and ethnic backgrounds: 104 identified as White, 24 as Other Race, 11 as Asian, 7 as Mixed Race, 5 as Black/African American, and 4 as Native Hawaiian or Pacific Islander.

In terms of ethnicity, 84 participants identified as Mexican American/Chicano, 8 as Other Hispanic/Latino, 2 as Hispanic/Latino, and 71 as Not Hispanic. The primary language for most participants was English (167), followed by Spanish (10) and Other (3). Participants also represented diverse sexual orientations—153 heterosexual, 8 bisexual, 4 gay or lesbian, and 1 queer, with 15 declining to state. The majority identified as female (145), followed by male (31) and genderqueer (1), with 4 declining to state.

Demographics



Estimated individuals served and cost per client:

Age	FY 23-24 Individuals Served	FY 24-25 Projected Individuals Served	FY 25-26 Projected Individuals Served
0-15 Children/Youth	0		
16-25 TAY	15		
26-59 Adults	135		
60+ Older Adults	26		
Demographics form not submitted	5		
Total	181	267	267
Contract amount	\$75,000	\$225,158	\$225,158
Cost per client	\$414.36	\$843.28	\$843.28

Outcome Highlights

During FY 23–24, the Mentis Suicide Prevention Program achieved major milestones in community training, outreach, and system coordination. Through MHSA PEI funding, the program trained 629 adults and 138 youth in Question, Persuade, Refer (QPR) suicide prevention, exceeding its goal of 250 gatekeepers. This included large-scale training for all primary-level school staff in Napa Valley Unified School District (NVUSD), covering 16 school sites and ensuring that thousands of students are surrounded by trusted adults equipped to identify and respond to early signs of distress.

Beyond training expansion, Mentis continued to provide leadership for the Napa County Suicide Prevention Council, chaired by the Mentis Prevention Director and supported by a bilingual Prevention Specialist. The Council enhanced its structure as a “working council”, increasing engagement and advancing coordinated prevention strategies countywide. A significant milestone was the completion and publication of the Napa County 3-Year Strategic Plan for Suicide Prevention, developed collaboratively with the Striving for Zero Learning Collaborative and Napa County Behavioral Health. The plan was finalized and released in both English and Spanish, marking a key achievement in aligning local efforts with statewide goals.

Outcome evaluation data demonstrated strong impact:

- 88% of QPR participants reported greater knowledge of suicide risks and available resources.
- 88% reported increased understanding that suicide is preventable.
- 79% reported greater willingness to ask for or seek help.

- 88% reported increased skills and confidence to question, persuade, and refer someone in crisis.

These results confirm that the program exceeded its outcome targets and is successfully strengthening community capacity to prevent suicide.

Challenges and Adaptations

The Mentis Suicide Prevention Program experienced several implementation challenges during FY 23–24. Coordinating large-scale QPR trainings across multiple schools and agencies required substantial planning, scheduling, and resource management. Sustaining engagement across sectors, particularly among organizations experiencing staff turnover or shifting priorities, also presented difficulties.

To address these barriers, Mentis expanded its training flexibility, offering tailored sessions for specific audiences and incorporating bilingual materials and Spanish-language sessions to increase accessibility. Program staff also launched a QPR workgroup within the Suicide Prevention Council to strengthen trainer coordination and maintain fidelity across sessions.

Additionally, the program relaunched its public awareness campaign featuring updated materials with the new 988 Suicide and Crisis Lifeline. Bus ads, flyers, and social media outreach were deployed countywide to promote awareness of suicide prevention resources. Despite coordination and resource challenges, these adaptations ensured the program maintained momentum and expanded its reach throughout Napa County.

Prevention Program Name:

Mentis – Safety Net for Youth Prevention Program

Target Population

The Mentis Safety Net for Youth Prevention Program serves middle school, high school, and college students ages 11–24 throughout Napa County. The program reaches a diverse population of young people, including bilingual, bicultural, and LGBTQ+ youth, who may experience social isolation, trauma, or stress that can contribute to emotional and behavioral challenges. Services are designed to be culturally responsive and accessible to both English- and Spanish-speaking families, promoting equitable access to prevention and early intervention supports across the county.

Program Description and Goals

The Safety Net for Youth Prevention Program provides peer-based and professional mental health prevention services that strengthen resilience, connection, and wellness among youth. The program integrates school-based education, community engagement, and family collaboration to promote early access to mental health supports and increase awareness of coping strategies and available resources.

Program Goals:

- Reduce isolation and increase youth knowledge of mental health issues, coping skills, and local resources for support.
- Encourage early access to prevention and early intervention services for youth experiencing emerging symptoms of emotional distress.
- Strengthen youth-adult connections by building caregiver and educator capacity to support youth well-being and recovery from trauma.

Key Activities and Services

During FY 23–24, the Mentis Safety Net for Youth Prevention Program implemented a broad range of MHSA-funded youth prevention activities that combined classroom instruction, peer engagement, and creative wellness initiatives.

At the middle school level, Mentis launched the Positivity Project (P2) across all 7th-grade classes in the Napa Valley Unified School District. The P2 curriculum, rooted in Positive Psychology, teaches 24-character strengths organized under six virtues, helping students build self-awareness, empathy, and social-emotional competence. Prevention Specialists visited classrooms monthly throughout the school year, using lessons, journaling, and group discussions to encourage reflection, self-regulation, and understanding of available mental health resources.

At the high school level, the program expanded its Teens Connect initiative, offering monthly Art & Wellness Workshops and hosting the second annual Youth Mental Health Festival. The festival featured creative activities such as affirmation cards, worry dolls, and identity buttons; physical wellness activities like yoga, hula hooping, and fitness sessions; and emotional wellness resources including therapy animals, financial literacy, and college/career planning stations. These interactive events helped reduce stigma, promote positive coping, and foster meaningful peer relationships.

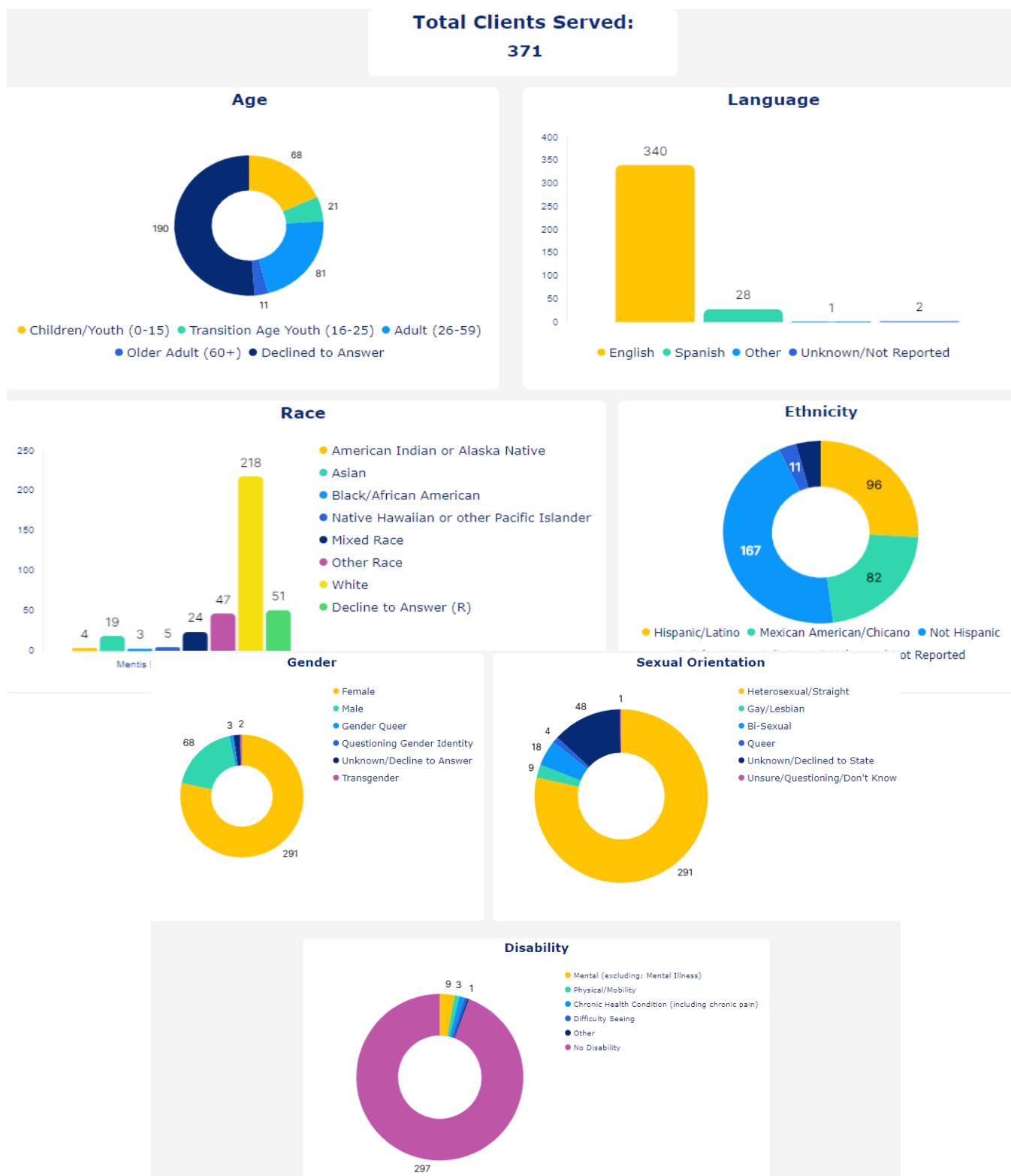
In addition, Mentis established a 25-member Teen Council representing high school students from across Napa County. Council members received leadership and advocacy training and worked collaboratively to plan community outreach, volunteer opportunities, and youth-led mental health campaigns. The Council's focus areas included Art & Wellness, Volunteer and Civic Engagement, and Youth Voice and Outreach, supporting sustained youth involvement and leadership in mental health awareness.

The program also delivered prevention education for parents and educators, engaging more than 200 adults in training sessions designed to increase understanding of youth stress, coping mechanisms, and trauma-informed support. Across all initiatives, Mentis fostered a collaborative environment that encouraged communication between youth, caregivers, and schools, helping to normalize mental health discussions and promote timely support.

Client Demographics and Service Volumes (FY 23–24)

During FY 23–24, the Mentis Safety Net for Youth Prevention Program served **371** participants through school and community-based prevention activities.

Demographics



Estimated individuals served and cost per client:

Age	FY 23-24 Individuals Served	FY 24-25 Projected Individuals Served	FY 25-26 Program Terminated on 6/30/25
0-15 Children/Youth	68	1521	
16-25 TAY	21	22	
26-59 Adults	81	23	
60+ Older Adults	11	0	
Total	371	1,566	
Contract amount	\$80,000	\$80,000	
Cost per client	\$215.63	\$51.09	

Outcome Highlights

The program achieved measurable success in enhancing youth engagement, leadership, and awareness of mental health resources. Through the district-wide implementation of the Positivity Project, all 7th-grade students in NVUSD gained improved understanding of self-awareness, empathy, and the importance of seeking help. At the high school level, the Teens Connect and Youth Mental Health Festival provided hands-on opportunities for students to explore emotional wellness and creative expression while promoting stigma reduction and peer connection.

The formation of the Mentis Teen Council strengthened youth leadership and advocacy, empowering 25 students to take an active role in shaping mental health initiatives in their schools and communities. The Council's summer training and planning sessions further equipped youth to develop events and outreach strategies for FY 24–25.

In addition to student-focused activities, the program trained and engaged over 200 parents and educators, ensuring that adults who work closely with youth are equipped with the tools to recognize early warning signs and connect young people to support. These combined efforts fostered a more connected, inclusive, and resilient community for Napa County youth.

Challenges and Adaptations

The program experienced challenges coordinating prevention services across multiple school sites, navigating scheduling conflicts, and maintaining student engagement amid academic and extracurricular demands. Mentis addressed these challenges by strengthening collaboration with district administrators, expanding peer-led programming, and offering flexible participation options to accommodate student schedules.

Additionally, the program enhanced its bilingual outreach to engage Spanish-speaking families and incorporated youth and educator feedback to refine lesson content and activities. These adaptations allowed the program to sustain engagement, improve accessibility, and continue to

build a countywide culture of youth wellness and support despite capacity and scheduling barriers.

Prevention Program Name:

Mentis – Student Connect Program

Target Population

The Mentis Student Connect Program serves Black, Indigenous, and People of Color (BIPOC) college students in Napa County between the ages of 16 and 24. This population often faces higher rates of depression, anxiety, trauma, and social isolation—particularly in the aftermath of the COVID-19 pandemic—yet is less likely to seek or receive mental health treatment compared to their white peers. The program is designed to address this disparity by providing culturally responsive prevention and early intervention services that reduce stigma, promote wellness, and build community connections among BIPOC students attending Napa Valley College (NVC) and other local institutions.

Program Description and Goals

The Student Connect Program provides peer-based and professional mental health prevention and early intervention supports to empower BIPOC college students to manage stress, strengthen coping skills, and access behavioral health resources early. The program fosters a culture of inclusion and mental wellness on campus through outreach, education, and capacity-building partnerships with college faculty and staff.

Program Goals:

- Train 10 BIPOC students as Peer Ambassadors/Counselors to lead campus-based wellness and mental health activities.
- Engage 150 BIPOC students in prevention and wellness initiatives, including wellness campaigns, monthly meetups, and Wellness Café discussions.
- Provide 100 BIPOC students and educators with mental health and suicide-prevention training and community education.
- Refer 50 BIPOC students to appropriate mental health treatment services at Napa Valley College, Mentis clinics, or community-based providers.

Key Activities and Services

During FY 23–24, the Mentis Student Connect Program implemented a comprehensive suite of outreach, prevention, and early intervention services designed to increase access and engagement among BIPOC college students.

Outreach and Education

Mentis conducted extensive outreach and education at Napa Valley College (NVC), reaching 742 individuals through on-campus events and informational sessions that raised awareness of available mental health resources and normalized help-seeking behaviors among BIPOC students.

Screenings and Referrals

Program staff conducted mental health screenings using validated assessment tools such as the *Patient Health Questionnaire (PHQ-9)* and the *Generalized Anxiety Disorder Scale (GAD-7)* to evaluate symptoms of depression, anxiety, trauma, and social isolation. Of the 95 students screened, 86 were referred for outpatient therapy—either through Mentis, NVC Counseling Services, or other community providers—demonstrating a strong linkage between prevention and early intervention.

Peer-Led Wellness Cafés

Mentis expanded its Wellness Café curriculum to include 18 topic areas, offering both one-time and recurring group sessions that addressed stress management, emotional regulation, academic balance, cultural identity, and healthy relationships. These sessions provided students with psychoeducation, peer support, and safe spaces to discuss mental health openly.

Training and Capacity Building

To strengthen campus readiness, Mentis provided Question, Persuade, and Refer (QPR) suicide-prevention training for college faculty, staff, and student leaders. This initiative prepared the college community to recognize early warning signs, intervene safely, and connect students in crisis with appropriate care. The QPR training was particularly timely in preparation for the opening of NVC's new residential housing in Fall 2024, ensuring staff and Peer Ambassadors are equipped to support students in both academic and residential settings.

Partnership and Integration

Mentis collaborated closely with NVC Deans, Counseling Services, and the Residential Housing Implementation Team to integrate behavioral health supports into campus systems. The program also engaged students through the NVC Men's Basketball Team, implementing the Wellness Café curriculum with athletes to promote teamwork, resilience, and emotional health.

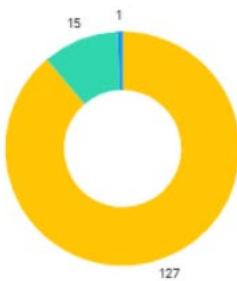
Client Demographics and Service Volumes (FY 23–24)

During FY 23–24, the Mentis Student Connect Program served a total of 143 participants.

Total Clients Served:

143

Age



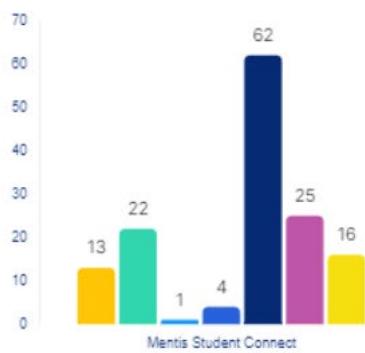
● Transition Age Youth (16-25) ● Adult (26-59) ● Older Adult (60+)

Language



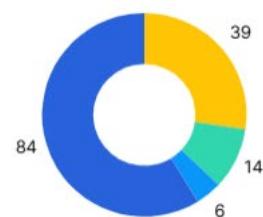
● Mantis Student Connect

Race



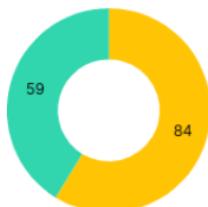
● Asian
● Black/African American
● Native Hawaiian or other Pacific Islander
● Mixed Race
● Other Race
● Race Not Available/Unknown
● White

Ethnicity



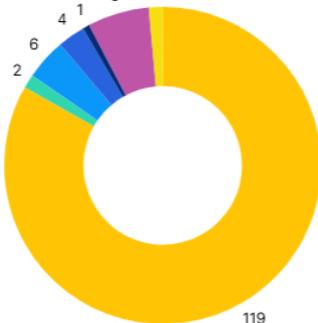
● Mexican American/Chicano ● Not Hispanic ● Other Hispanic/Latino
● Unknown/Not Reported

Gender



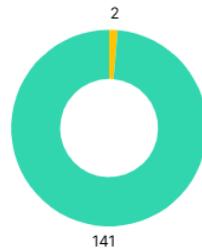
● Female ● Male

Sexual Orientation



● Heterosexual/Straight
● Gay/Lesbian
● Bi-Sexual
● Another Sexual Identity
● Queer
● Unknown/Declined to State
● Unsure/Questioning/Don't Know

Disability



● Mental (excluding: Mental Illness)
● No Disability

Estimated individuals served and cost per client:

Age	FY 23-24 Individuals Served	FY 24-25 Projected Individuals Served	FY 25-26 Program Terminated on 6/30/25
0-15 Children/Youth			
16-25 TAY	127	127	
26-59 Adults	15	15	
60+ Older Adults	1	1	
Total	143	143	
Contract amount	\$97,540	\$97,540	
Cost per client	\$682	\$682	

Outcome Highlights

During FY 23–24, the Student Connect Program made significant strides in building a more inclusive and supportive mental health culture on campus. Outreach efforts reached hundreds of students, increasing visibility of mental health resources and reducing stigma around accessing services. Mentis' outreach and screening efforts led to 86 students being referred for therapy, a key measure of early intervention success.

Partnerships with campus groups, including the NVC Men's Basketball Team, effectively introduced Wellness Café activities to student-athletes, while general student participation in Wellness Cafés demonstrated strong engagement and satisfaction. Mentis staff also worked closely with the college administration to train faculty and staff through QPR suicide-prevention workshops, strengthening the safety net for students who may be struggling.

The expansion of 18 Wellness Café modules provided diverse, culturally responsive programming tailored to student needs, focusing on academic stress, cultural identity, and interpersonal relationships. Collectively, these initiatives improved student awareness, access to supports, and confidence in seeking help.

Challenges and Adaptations

The Student Connect Program encountered challenges during the year, primarily related to high demand for therapy services and limited clinical capacity. As a result, a therapy waitlist was created. In response, Mentis expanded Wellness Cafés as an interim support strategy, providing students awaiting therapy with foundational mental health education, stress management tools, and peer connection opportunities.

Technical issues during the early part of the year limited post-session data collection for some Wellness Café events. Staff addressed this by refining data-tracking methods, implementing clearer intake processes, and enhancing coordination between outreach and clinical teams.

Additionally, as the college prepared to launch its new residential housing program, Mentis worked with campus administrators to develop plans for integrating behavioral health supports into the residential environment. This transition required additional staff training, onboarding of new Peer Ambassadors, and collaborative planning to align program delivery with housing operations.

Despite these challenges, the program demonstrated flexibility and innovation. Mentis successfully adapted to meet student needs, strengthened institutional partnerships, and established sustainable foundations for campus-based prevention and early intervention services.

Prevention Program Name:

Mentis – Bridges Community Mental Health Program

Target Population

The Mentis Bridges Program serves uninsured and underinsured adults ages 18 to 60 throughout Napa County who experience increased levels of depression, anxiety, trauma, and stress. Many clients are monolingual Spanish speakers who face cultural, linguistic, and financial barriers when seeking traditional mental-health services. The program prioritizes individuals with limited access to care and focuses on early intervention and prevention strategies designed to reduce emotional distress, prevent symptom escalation, and improve overall well-being.

Program Description and Goals

As Napa County continues to recover from the pandemic, many vulnerable residents continue to experience significant personal challenges, including heightened anxiety, depression, trauma, and family instability. The Bridges Community Mental Health Program was developed to address these ongoing needs by providing short-term, early-intervention therapy in accessible, familiar settings and through telehealth. The program uses evidence-based approaches to promote emotional stability, improve functioning, and prevent the need for higher levels of care.

Program Goals:

- Identify clients at risk for self-harm and provide early intervention.
- Screen for suicidal ideation and risk factors throughout treatment.
- Provide crisis support and safety planning to maintain client stability.
- Deliver brief therapy and early-intervention services in accessible and culturally competent settings.
- Improve clients' mental health by reducing distress, depression, and anxiety while preventing worsening symptoms and promoting daily functioning.

Key Activities and Services

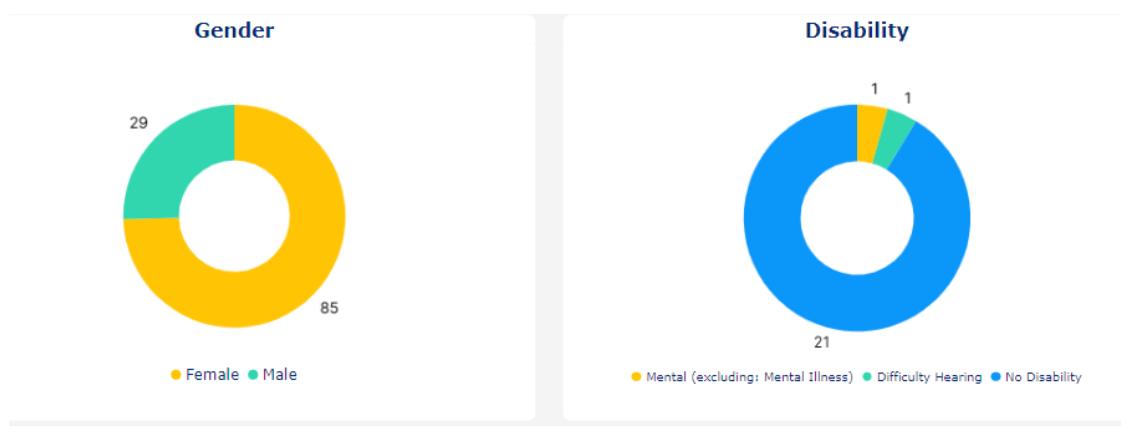
During FY 23–24, Mentis provided early-intervention and brief therapy to uninsured and underinsured adults across Napa County using evidence-based treatment modalities, including Cognitive Behavioral Therapy (CBT), Cognitive Processing Therapy (CPT), and Motivational Interviewing (MI).

Core activities included comprehensive assessments, risk screenings, and the delivery of 8–15 therapy sessions per client, typically lasting 50–60 minutes each. Clinicians provided care coordination with referring agencies, linked clients to community resources, and maintained bilingual service delivery to ensure access for Spanish-speaking residents. Crisis intervention and safety planning were also offered when clients presented with acute distress.

Throughout the fiscal year, Mentis delivered more than 860 therapy sessions to 97 clients, offering accessible, short-term mental-health support to community members who might otherwise remain unserved.

Demographics





Estimated individuals served and cost per client:

Age	FY 23-24 Individuals Served	FY 24-25 Program moved to CSS Funding	FY 25-26 Program moved to CSS Funding
0-15 Children/Youth	0		
16-25 TAY	0		
26-59 Adults	97		
60+ Older Adults	0		
Total	114		
Contract amount	\$150,000		
Cost per client	\$1,315.79		

Outcome Highlights

The Bridges Program achieved strong outcomes during FY 23–24, demonstrating meaningful reductions in depression, anxiety, and trauma symptoms among participants. Clients received individualized early-intervention therapy, with most showing measurable improvement across standardized clinical measures.

By year-end, 69% of clients reported improved emotional health, 87% reported reduced depression symptoms, and 75% reported decreases in both anxiety and trauma symptoms. Clients also described enhanced coping skills, stronger emotional regulation, and improved functioning in daily life.

These results highlight the program's success in delivering culturally responsive, accessible mental-health care to underserved adults in Napa County and align with its prevention and early-intervention objectives.

Challenges and Adaptations

While the program achieved significant progress, clinicians noted an increase in both the severity

and complexity of clients' mental-health needs compared to prior years. Many individuals continued to experience prolonged stress due to economic hardship, family strain, chronic health conditions, and post-pandemic uncertainty. These factors extended treatment duration and required higher levels of clinical support.

To adapt, Mentis expanded telehealth availability, increased crisis-response capacity, and enhanced care coordination with community partners and healthcare providers. The program also relied on bilingual clinicians to provide culturally and linguistically appropriate support, ensuring equitable service delivery for monolingual Spanish-speaking clients.

Despite these challenges, the Bridges Program successfully met its annual targets and maintained strong engagement, providing effective, compassionate, and timely mental-health care to Napa County's underserved adult population.

Prevention Program Name:

Molly's Angels Comprehensive Assistance and Resources for Elderly (CARE)

Target Population

The Molly's Angels CARE Program serves older adults aged 60 and above living in low-income and rural communities throughout Napa County, including Up Valley regions. The program primarily supports individuals experiencing social isolation, limited mobility, or barriers to transportation and healthcare access. Participants often face chronic medical conditions, disabilities, or limited social supports. The program is inclusive of both English and Spanish-speaking seniors, with a focus on reaching monolingual Hispanic older adults through targeted bilingual outreach and culturally responsive engagement.

Program Description and Goals

The Molly's Angels CARE Program provides comprehensive outreach, engagement, transportation, and mental health screening services designed to enhance the quality of life for older adults across Napa County. The program reduces the risks associated with social isolation, geriatric depression, and poor health outcomes by connecting older adults with caring volunteers, consistent communication, and wrap-around supportive services. Through this prevention-based model, participants maintain independence, access essential resources, and build social connections that support long-term well-being.

Program Goals:

- Decrease social isolation and loneliness among older adults.
- Increase access to transportation, healthcare, and social supports.
- Provide early identification and referral for depression or loneliness.
- Promote inclusion, well-being, and independence through consistent engagement.

Key Activities and Services

Older adults are at heightened risk for depression and loneliness due to life transitions, the loss of loved ones, and mobility or health challenges. To address these needs, Molly's Angels implements a comprehensive prevention model that integrates transportation, outreach, and volunteer-driven engagement with evidence-based mental health screening and follow-up.

The program provides free, door-to-door transportation to medical and social appointments, enabling older adults to access care, maintain independence, and reduce the stress associated with missed or delayed services. In FY 23–24, over 4,000 rides were provided across the county. The Hello Molly Care Calls program offers consistent, friendly phone check-ins that reduce loneliness and provide an opportunity to screen for emerging mental health concerns. Volunteers completed more than 1,400 calls during the fiscal year, including birthday wellness check-ins guided by the UCLA Loneliness Scale.

Each client receives a Short Form Geriatric Depression Scale and UCLA 3-Item Loneliness Screening, with results used to determine appropriate referrals to programs such as Mentis Healthy Minds Healthy Aging, Providence Community Health, Napa County APS, and Up Valley Family Centers. In FY 23–24, over 430 screenings were completed, including 38 in Spanish for clients who do not speak English. Staff and volunteers also completed Mental Health First Aid and QPR Gatekeeper suicide prevention training to strengthen early identification and support capacities.

Client Demographics and Service Volumes (FY 23–24)

During FY 23–24, Molly's Angels served more than 1,600 seniors across Napa County. The majority of participants identified as female and White or Latino, with a growing proportion of monolingual Spanish-speaking older adults engaged through bilingual outreach. The program maintained a strong Up Valley presence, with staff regularly stationed at Rianda House in St. Helena and the Up Valley Family Center in Calistoga.

Across the fiscal year, the program achieved:

- 3,000–4,000 rides per quarter (averaging 370–420 per month).
- Approximately 1,400 Care Calls annually, including 275 birthday wellness check-ins.
- 40–80 new clients enrolled per quarter.
- Over 430 mental health screenings completed with ongoing follow-up calls and referrals.

Estimated individuals served and cost per client:

Age	FY 23-24 Individuals Served	FY 24-25 Projected Individuals Served	FY 25-26 Projected Individuals Served
0-15 Children/Youth			
16-25 TAY			
26-59 Adults			
60+ Older Adults	1,656	1,656	1,656
Total	1,656	1,656	1,656
Contract amount	\$103,680	\$144,000	\$144,000
Cost per client	\$63	\$87	\$87

Outcome Highlights

The CARE Program demonstrated measurable success in increasing social connectedness, improving access to care, and promoting early identification of mental health needs. Ninety-eight percent of participants reported feeling more connected and supported after participating in the program, and 92 percent were able to attend medical appointments they otherwise would have missed.

Molly's Angels strengthened collaboration and outreach by joining the Napa County Mental Health Stakeholder Advisory Committee, developing and distributing a bilingual Mental Health Resource Booklet, and hosting or attending more than a dozen community events, including health fairs, farmers markets, and senior wellness gatherings. The program's ongoing partnership with local radio through the Senior Moments show provided education on topics such as mental wellness, caregiving, and community resources.

Volunteer engagement expanded significantly, with new bilingual volunteers recruited and trained in suicide prevention and Mental Health First Aid. These combined efforts enhanced the program's capacity to identify at-risk seniors and provide early, preventive support.

Challenges and Adaptations

The program continued to face challenges related to volunteer recruitment, transportation coordination in rural areas, and technology barriers that limit older adults' ability to access digital resources. In response, Molly's Angels strengthened collaboration with senior centers, churches, and community partners to identify isolated seniors and recruit new volunteers. The organization implemented scheduling improvements and route optimization to increase transportation reliability and expanded bilingual outreach and printed materials to ensure accessibility for Hispanic participants.

Partnerships with Providence Community Health provided ongoing Mental Health First Aid training for staff and volunteers, reinforcing a compassionate, prevention-focused approach.

These adaptations have improved service coordination, broadened outreach, and deepened the program's connection to Napa County's diverse older adult population, solidifying its role as a cornerstone of the county's prevention and early intervention network.

Prevention Program Name:

NEWS Kids Exposed to Domestic Violence (KEDS)

Target Population

The NEWS Kids Exposed to Domestic Violence (KEDS) Program serves children and youth ages 3 to 18 who have witnessed or experienced domestic violence in their homes. Many participants come from low-income, single-parent households that also face housing instability, trauma, or limited access to behavioral health resources. The program also engages non-abusive parents or caregivers to strengthen their capacity to support their children's recovery. Services are available in both English and Spanish, ensuring cultural and linguistic responsiveness to Napa County's diverse families.

Program Description and Goals

The KEDS Program provides trauma-informed prevention and early intervention services to children and families affected by domestic violence. Through case management, parent and child support groups, and strong collaboration with local partners, the program works to reduce the emotional and behavioral effects of trauma, build protective factors, and prevent the long-term mental health consequences associated with exposure to violence.

Program Goals:

- Reduce the emotional and behavioral impacts of witnessing domestic violence.
- Strengthen parent-child attachment and family stability through education and guided interventions.
- Increase coping skills, resilience, and social-emotional regulation in children.
- Improve access to culturally responsive mental health supports in both English and Spanish.
- Strengthen cross-agency collaboration and referral pathways to ensure timely, coordinated care for families.

Key Activities and Services

KEDS employs a three-pronged approach to addressing the needs of children and parents impacted by domestic violence.

1. Case Management and Family Support:

The KEDS Advocate conducts intakes and assessments with families referred by NEWS' crisis and emergency response teams. Each family receives individualized support to identify needs,

connect to community resources, and access flexible financial assistance for essentials such as school supplies, children’s activities, and utilities. In FY 23–24, 52 families were enrolled in the KEDS Program, and 12 families received in-depth trauma-informed case management.

2. Parent and Child Support Groups:

In partnership with Mantis, NEWS hosted two twelve-week closed support groups for parents and children—offered in both English and Spanish. Approximately 13 families, including 10 children, participated in FY 23–24. Sessions integrated lessons from *A Window Between Worlds* to help children express feelings, understand boundaries, and learn healthy coping mechanisms. Parents attended parallel sessions focused on emotional regulation, parenting after trauma, and nurturing positive family relationships.

3. Collaboration and Community Education:

NEWS facilitated quarterly KEDS Collaborative Meetings bringing together community partners such as schools, child welfare agencies, and therapeutic childcare providers to improve coordination and referrals. KEDS staff also participated in community prevention events, including COPE’s Kids Day, Walk a Mile in Her Shoes, and outreach at local middle schools to raise awareness of the effects of domestic violence on children and available services.

Client Demographics and Service Volumes (FY 23–24)

By the close of FY 23–24, the KEDS Program had served over 50 families, including more than 80 children across Napa County. The majority of children served were between the ages of 3 and 10, with most families identifying as Latino. About 40% of services were delivered in Spanish, reflecting the County’s ongoing emphasis on cultural and linguistic accessibility.

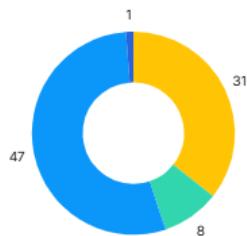
Flexible financial assistance totaling \$10,000 supported essential needs that strengthened family stability. Parents and caregivers participated in structured case management meetings at least twice during enrollment, and many continued engagement through support groups or referrals to ongoing therapy.

Demographics

Total Clients Served:

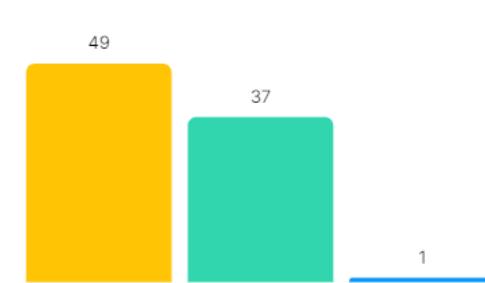
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Age



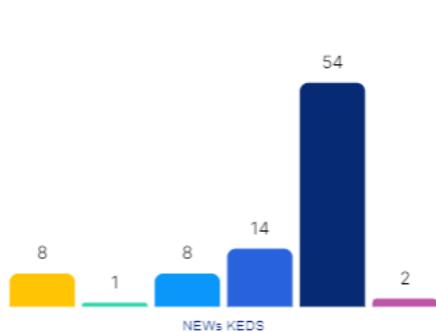
● Children/Youth (0-15) ● Transition Age Youth (16-25) ● Adult (26-59)
● Declined to Answer

Language

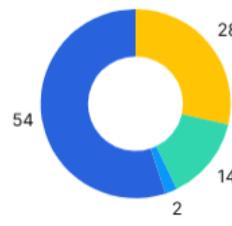


● English ● Spanish ● Unknown/Not Reported

Race

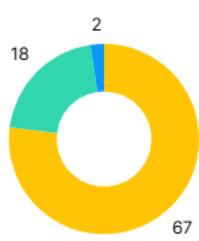


Ethnicity



● Mexican American/Chicano ● Not Hispanic
● Other Hispanic/Latino ● Unknown/ Not Reported

Gender



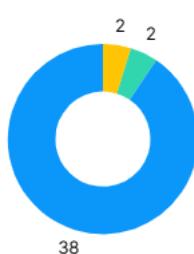
● Female ● Male
● Unknown/Decline to Answer

Sexual Orientation



● Heterosexual/Straight
● Unknown/Declined to State

Disability



● Mental (excluding: Mental Illness)
● Physical/Mobility ● No Disability

Estimated individuals served and cost per client:

Age	FY 23-24 Individuals Served	FY 24-25 Contract not renewed	FY 25-26 Contract not renewed
0-15 Children/Youth	31		
16-25 TAY	8		
26-59 Adults	47		
60+ Older Adults	0		
Decline to state	1		
Total	87		
Contract amount	\$130,054		
Cost per client	\$1,495		

Outcome Highlights

KEDS achieved measurable improvements in both parental confidence and child emotional wellness during FY 23–24:

- 67% of parents reported improved ability to meet their children’s basic needs and observed their children being “more calm” and “less anxious.”
- 100% of parents completing post-group surveys indicated increased confidence in supporting their children’s emotional recovery.
- 80% of parents reported decreased anxiety and stress among their children after participating in support groups.
- Increased access to bilingual counseling and peer-based healing supports in Napa County, with tailored Spanish-language groups for parents of children exposed to domestic violence.
- Strengthened interagency partnerships through quarterly KEDS Collaborative Meetings and active participation in countywide prevention events.

Parents and children demonstrated improved coping skills, communication, and emotional regulation—protective factors that reduce the likelihood of developing severe mental health symptoms later in life.

Challenges and Adaptations

The program encountered challenges with client engagement and follow-up, as many parents navigating post-crisis transitions faced competing priorities such as housing, employment, and childcare. Low enrollment in case management reflected these real-world barriers.

To adapt, NEWS modified the engagement process by implementing shorter, bi-weekly check-ins instead of weekly meetings, offering flexible scheduling, and re-framing case management as supportive coaching to increase participation. NEWS also strengthened its collaboration with Napa Valley Unified School District and other partners to improve referral systems and co-hosted bilingual outreach presentations for social workers and parent liaisons.

Additional adaptations included enhanced trauma-informed training for staff, streamlined intake procedures, and expanded outreach to Up Valley communities. These efforts helped sustain engagement and ensure that both parents and children received compassionate, culturally responsive support during recovery.

Prevention Program Name:

NVEF Wellness Centers as Hubs for Access & Intervention

Napa Valley Education Foundation (NVEF) – Wellness Centers as Hubs for Access and Intervention

Target Population

The NVEF Wellness Centers serve students throughout Napa County's elementary, middle, and high schools, ensuring equitable access to behavioral-health screenings, prevention education, and early-intervention services. The program primarily supports children and transition-age youth (ages 10–25) who experience social, emotional, and academic challenges related to trauma, stress, or isolation caused by natural disasters, economic hardship, and the COVID-19 pandemic. The Wellness Centers are designed to meet the diverse needs of Napa County's student population, providing bilingual and bicultural supports for Hispanic and Latino youth, who represent the majority of participants. The program's focus on early identification and culturally responsive care ensures that all students can access help within trusted school environments before issues escalate.

Program Description and Goals

The NVEF Wellness Centers as Hubs initiative creates safe, accessible spaces on school campuses where students can receive mental-health screenings, counseling, and linkages to wellness supports. Each Wellness Center serves as a centralized hub for prevention and early-intervention activities coordinated among students, educators, parents, and behavioral-health professionals. By embedding services directly within schools, the program helps normalize conversations about mental health, reduce stigma, and ensure that students receive timely, appropriate support.

This model aligns with the California Department of Education's Multi-Tiered System of Support (MTSS) and the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) goals of reducing risk factors and promoting resilience among youth. Through collaboration with Napa

County Behavioral Health, Mentis, and community partners, the program bridges educational and mental-health systems to support whole-child wellness.

Program Goals:

- Provide universal behavioral-health screenings for all secondary students using the Strengths and Difficulties Questionnaire (SDQ).
- Identify and support students who meet criteria for Tier 2 and Tier 3 levels of care through school-based counseling or community referral.
- Increase students' coping skills, resilience, and awareness of available mental-health resources.
- Train all instructional staff in equity-based, trauma-informed Social Emotional Learning (SEL) practices.
- Ensure culturally and linguistically responsive access to services for all students.

Key Activities and Services

NVEF employs a comprehensive, school-based prevention model centered on collaboration, early identification, and student empowerment. All middle and high school students receive behavioral-health screenings using the SDQ to assess emotional well-being and identify those who may need additional support. Screening results are reviewed collaboratively by counselors, teachers, and administrators to determine appropriate interventions and ensure early connection to care.

Wellness Centers operate in four middle schools and three high schools across the district. Each site is staffed with a school counselor or licensed social worker who provides one-on-one counseling, group sessions, crisis intervention, and ongoing support. In partnership with VOICES Napa, a full-time Youth Outreach Coordinator provides peer engagement and mentoring services, fostering trust and helping to reduce the stigma surrounding mental-health care. The program also ensures that students and families are connected to community-based providers, including Napa County Behavioral Health and Mentis, for higher levels of care when needed.

Additionally, all instructional staff received equity-based and trauma-informed Social Emotional Learning (SEL) training, strengthening the ability of teachers and school staff to identify early signs of distress and support student well-being within the classroom. Across all sites, the program recorded between 200 and 300 student visits each week at high-school Wellness Centers, demonstrating the strong reach and relevance of these services.

Client Demographics and Service Volumes (FY 23–24)

During FY 23–24, the Wellness Centers served a total of 130 students across participating schools. Of those, 34 were children and youth ages 0–15, and 96 were transition-age youth ages 16–25. The majority of participants identified as Hispanic/Latino (73%), reflecting the program's strong engagement with bilingual students and families. In terms of race, most participants identified as

White (86%), with smaller proportions identifying as Asian (3%) and American Indian/Alaska Native (1%).

Of the 68 students who reported gender identity, 39 identified as female, 24 as male, and 5 declined to answer. The total contract amount for FY 23–24 was \$310,359, resulting in an average cost per client of \$2,387.38. These data reflect consistent outreach and service delivery across multiple schools and support the program's focus on equitable access to prevention and early-intervention services for Napa County youth.

Demographics



Estimated individuals served and cost per client:

Age	FY 23-24 Individuals Served	FY 24-25 Contract Terminated	FY 25-26 Contract Terminated
0-15 Children/Youth	34		
16-25 TAY	96		
26-59 Adult	0		
60+ Older Adult	0		
Total	130		
Contract amount	\$310,359		
Cost per client	\$2,387.38		

Outcome Highlights

The NVEF Wellness Centers have become an essential component of Napa County's school-based behavioral-health network. During FY 23–24, the program successfully implemented universal behavioral-health screenings for all secondary students and achieved full participation of instructional staff in trauma-informed SEL training. The Wellness Centers consistently maintained high levels of student engagement, averaging 200–300 weekly visits at high-school sites.

Students who accessed Wellness Center services demonstrated measurable improvements in coping skills, self-regulation, and resilience. Teachers and administrators observed greater classroom participation and fewer behavioral disruptions among students who regularly used the centers. The program's strong emphasis on peer support, wellness education, and stigma reduction has helped normalize help-seeking behaviors among students.

These outcomes collectively highlight the effectiveness of embedding prevention and early-intervention services directly within school environments, ensuring that mental-health support is accessible, responsive, and aligned with students' day-to-day experiences.

Challenges and Adaptations

The NVEF Wellness Centers continue to face challenges related to staff capacity, fluctuating funding, and rising demand for youth mental-health services. The ongoing behavioral-health workforce shortage and the need to maintain stable funding streams have been significant barriers to sustaining program growth.

In response, NVEF implemented several adaptations to strengthen continuity of care and service delivery. The organization cross-trained counselors and school staff to ensure consistent coverage across campuses, expanded telehealth counseling options when in-person services were unavailable, and launched a peer wellness ambassador program to promote outreach and student engagement. Additionally, NVEF deepened collaboration with Napa County Behavioral

Health and other community agencies to enhance referral pathways and leverage shared resources.

Despite these challenges, the Wellness Centers have maintained consistent, high-quality services that prioritize prevention, accessibility, and student-centered care. Their continued operation represents a key achievement in building a sustainable, school-based system of mental-health support in Napa County.

Prevention Program Name:

On The Move – VOICES Napa: Guaranteed Income for Foster Youth

Target Population

The Guaranteed Income for Foster Youth Program serves transition-age youth (TAY) ages 16–25 in Napa County who are currently or formerly in the foster-care system. These young adults are among the most vulnerable members of the community, often facing housing instability, food insecurity, limited access to health care, and barriers to financial independence. The program specifically targets youth receiving Extended Foster Care (EFC) and Medi-Cal benefits, ensuring that participation does not negatively impact their eligibility for public assistance. The initiative provides bilingual and culturally responsive support to ensure equitable access for all participants, particularly those from historically marginalized backgrounds.

Program Description and Goals

The VOICES Napa: Guaranteed Income for Foster Youth Program, implemented by On The Move (OTM) in collaboration with Napa County Behavioral Health and Child Welfare Services, was established to address the economic and mental-health challenges faced by former and current foster youth. Financial insecurity and instability have been identified as key contributors to chronic stress, depression, and anxiety among young adults exiting foster care. This pilot program combines unconditional monthly cash payments with LIFE coaching and financial education to stabilize participants' income and improve mental health, housing, employment, and educational outcomes.

The program aligns with MHSA's Prevention and Early Intervention (PEI) priorities by reducing risk factors associated with poverty, trauma, and system involvement, and by fostering protective factors such as self-determination, financial literacy, and stable housing.

Program Goals:

- Provide 18 months of guaranteed income payments to foster youth participants to improve financial stability and reduce stress.
- Deliver monthly LIFE coaching and financial education sessions tailored to each participant's goals.

- Ensure program income does not interfere with Medi-Cal, CalFresh, or CalWORKs eligibility by maintaining benefit exemptions.
- Strengthen youth financial resilience, credit awareness, and long-term planning skills.
- Enhance participant well-being by reducing financial stress and promoting emotional and mental stability.

Key Activities and Services

The program was implemented in three phases: Planning, Enrollment, and Disbursement.

During the Planning Period, VOICES developed the program design, created application materials, and collaborated with Napa County staff to obtain waivers from the California Department of Social Services (CDSS) to ensure that guaranteed-income payments would be excluded from benefits calculations for CalWORKs and CalFresh. Staff also worked closely with youth to prepare applications, gather necessary documents, and establish personal budgets and financial goals.

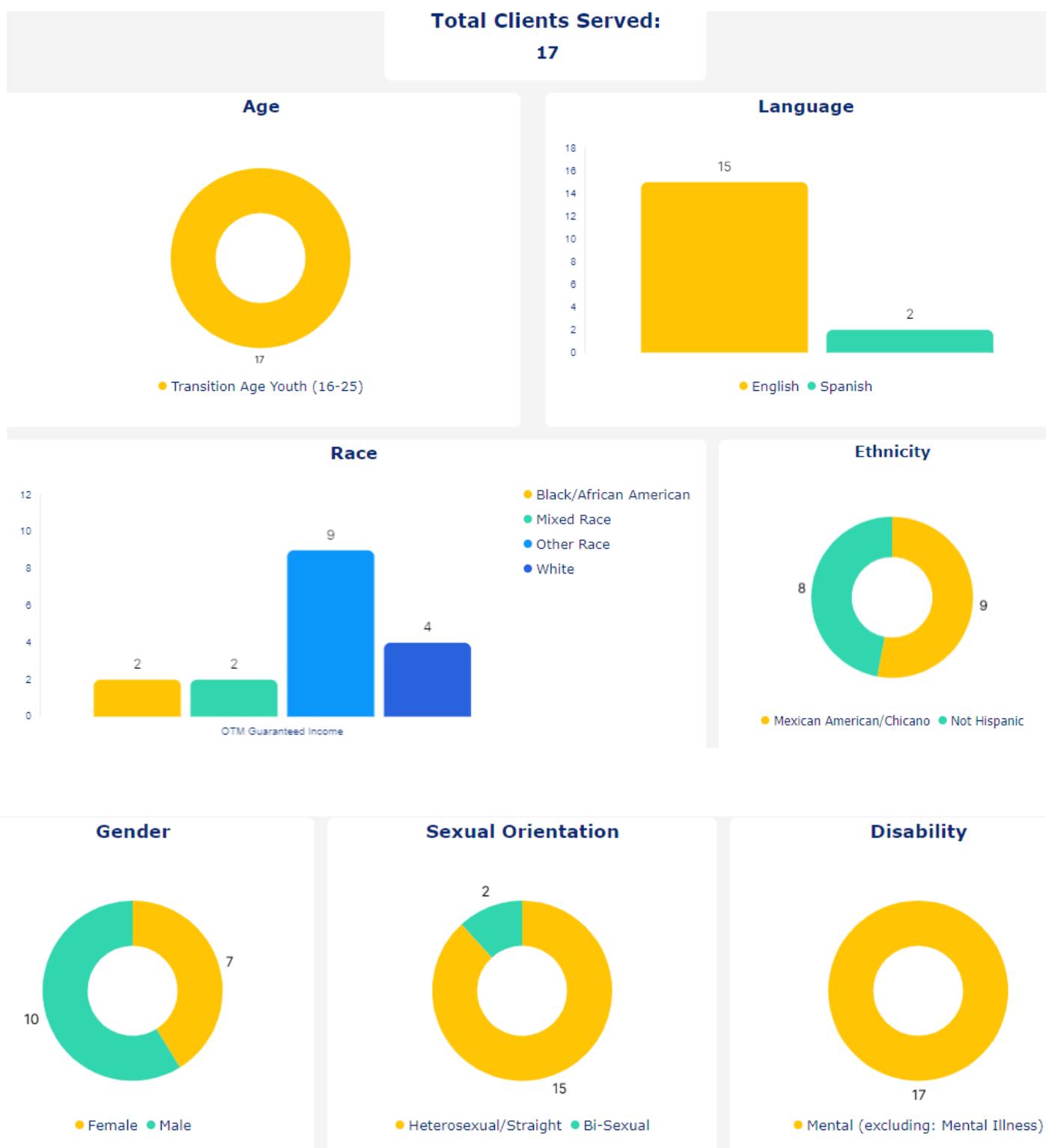
In the Enrollment Phase, VOICES assessed youth for eligibility, provided benefits counseling, and enrolled 17 participants. Among them, 86% were enrolled in Medi-Cal, 57% received Extended Foster Care benefits, and 36% received Transitional Housing Program (THP) housing support. Each youth collaborated with a LIFE coach to establish personal goals related to housing, education, employment, and financial independence.

The Disbursement Phase began in January 2024, with participants receiving \$1,000 monthly payments via check or direct deposit. VOICES assisted participants without bank accounts in establishing one through local banking partnerships. Youth met monthly with VOICES staff and, when applicable, their social worker or probation officer to participate in LIFE coaching sessions focused on financial literacy, goal setting, and resource connection.

Client Demographics and Service Volumes (FY 23–24)

A total of 17 youth were enrolled in the Guaranteed Income Program during FY 23–24. All participants were transition-age youth (ages 16–25).

Demographics



Estimated individuals served and cost per client:

Age	FY 23-24 Individuals Served	FY 24-25 Projected Individuals Served	FY 25-26 Contract not renewed
0-15 Children/Youth	0	0	
16-25 TAY	17	17	
26-59 Adult	0	0	
60+ Older Adult	0	0	
Total	17	17	
Contract amount	\$146,098	\$86,956	
Cost per client	\$8,594	\$5,115	

Outcome Highlights

The Guaranteed Income for Foster Youth Program produced strong early results during its first six months of implementation. All 17 youth received program orientation and began receiving monthly payments in January 2024. VOICES conducted a midyear progress survey to assess financial and emotional well-being.

Key outcomes include:

- 53% of participants used their payments to cover unexpected expenses, avoiding new debt.
- 50% reported decreased financial stress within six months of program enrollment.
- 80% reported progress toward achieving financial goals such as securing housing, paying for education, or saving for transportation.
- 100% of participants received LIFE coaching, financial education, and benefits counseling.

Additionally, many participants opened their first bank accounts and established consistent monthly budgets, representing meaningful steps toward independence. By reducing financial stressors, the program contributed to improved self-confidence, decision-making, and mental health among participants.

Challenges and Adaptations

Initially, determining program eligibility and navigating the complexities of Extended Foster Care requirements presented challenges. VOICES collaborated with Napa County Child Welfare Services to clarify eligibility criteria, ensuring the inclusion of as many eligible youth as possible without affecting their public benefits.

Recruitment also required targeted outreach to reach youth who were eligible but hesitant to enroll due to confusion about benefit impacts. To address this, VOICES staff conducted one-on-

one information sessions and coordinated with probation officers, independent living program specialists, and caseworkers.

As a pilot initiative, the program continues to adapt its evaluation framework in alignment with the statewide Guaranteed Income pilot led by the Urban Institute, allowing Napa County's results to contribute to a broader understanding of guaranteed-income impacts on foster youth well-being.

Prevention Program Name:

Up Valley Mentoring Program (CLARO/A)

Target Population

The CLARO (Challenging Latinos to Access Resources and Opportunities) and CLARA (Challenging Latinas through Awareness, Resources, and Action) programs serve Latinx middle and high school students and their families in the St. Helena and Calistoga areas. These Up Valley communities experience limited access to behavioral-health services, particularly for youth and Spanish-speaking families. CLARO/A focuses on youth mentorship, leadership development, and mental health prevention, providing culturally grounded support that integrates family engagement, academic guidance, and community involvement.

Program Description and Goals

The CLARO/CLARA Mentorship Program was established to address disparities in mental-health awareness and access among Latinx youth in rural Up Valley areas. Through school-based mentoring, leadership activities, and family engagement, the program builds confidence, fosters resilience, and helps youth navigate academic, social, and emotional challenges. Mentors incorporate Latinx cultural traditions and values while promoting healthy lifestyles, emotional regulation, and self-advocacy.

The program's activities align with MHSA Prevention and Early Intervention (PEI) goals by reducing risk factors associated with isolation, stigma, and substance use while promoting protective factors such as leadership, peer support, and positive identity development. CLARO/A youth learn to identify signs of mental-health distress, practice help-seeking behaviors, and connect peers and families to appropriate resources.

Program Goals:

- Increase youth knowledge of mental health and available community resources.
- Build leadership skills, confidence, and positive cultural identity among Latinx youth.
- Reduce stigma around mental-health conversations in schools and families.
- Strengthen family engagement and promote healthy communication.

- Foster academic motivation, self-expression, and resilience through culturally grounded mentorship.

Key Activities and Services

Throughout FY 23–24, CLARO/A mentors provided consistent school-based engagement and coordinated prevention activities in partnership with St. Helena and Calistoga Unified School Districts. Activities were aligned with the school calendar and community events to maximize participation.

In Fall 2023, the program supported Red Ribbon Week across both districts under the theme “*Be Kind to Your Mind*,” focusing on prevention, mental-health awareness, and healthy decision-making. Students organized classroom visits, art activities, and tabling events promoting wellness and substance-use prevention. CLARA alumni also supported a Parent Night in collaboration with Nimbus Arts and Teens Connect, combining art, mental-health education, and family bonding.

During Winter 2024, youth explored topics around healthy relationships as part of the program’s annual relationship unit. CLARA middle and high school groups organized their own Orange4Love Campaign on teen dating violence awareness, reaching more than 50 students through student-led activities. Youth also participated in the Napa Valley Wellness Conference, where several CLARA students presented on youth mental health, returning to share insights and lead peer discussions.

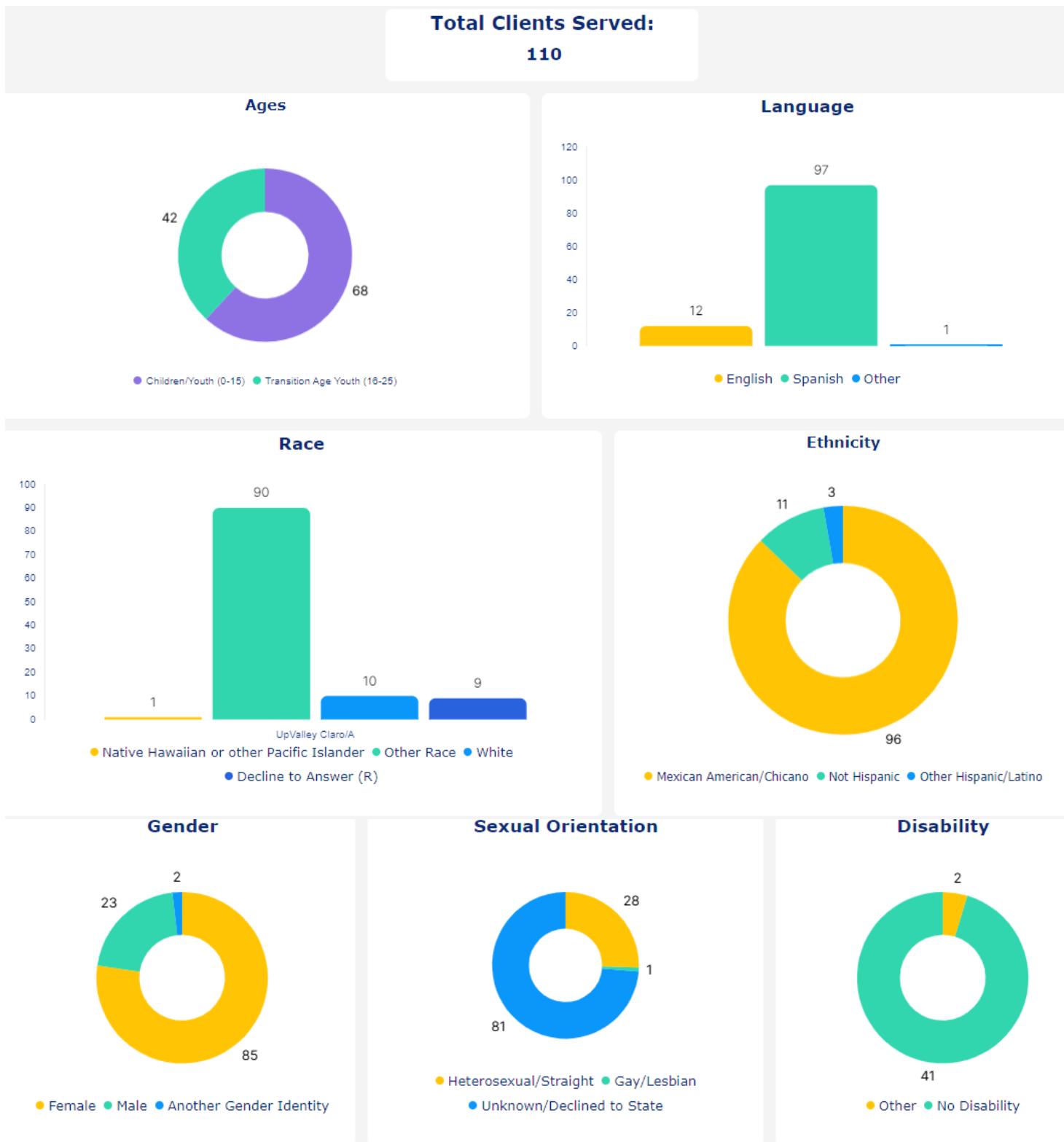
In Spring 2024, the program launched several major initiatives. A student-driven Mental Health Resource Fair at St. Helena High School marked the program’s first youth-led event of its kind. CLARA and CLARO participants coordinated with community partners including Aldea Behavioral Health, Nimbus Arts, and UpValley Family Centers’ Case Management Team. Concurrently, Calistoga students organized a Wellness Fair with interactive activities such as “Mental Health Rocks,” a self-care station, and a trivia challenge focused on coping strategies and emotional wellness.

The program also hosted UpValley Youth Adventures, college exploration and wellness trips to San Jose State University and UC Santa Cruz, where students reported increased confidence in pursuing higher education and understanding mental health supports available in college settings.

At the close of the school year, CLARO/A celebrated graduating seniors through its CLARO/A Scholar Highlights tradition—recognizing academic achievements, leadership contributions, and postsecondary goals.

Client Demographics and Service Volumes (FY 23–24)

The CLARO/A Program served a total of 110 individuals during FY 23–24, primarily youth between the ages of 12 and 18. The majority of participants identified as Spanish-speaking Mexican American youth, reflecting the program's strong reach within Up Valley's Latinx community.



Estimated individuals served and cost per client:

Age	FY 23-24 Individuals Served	FY 24-25 Projected Individuals Served	FY 25-26 Projected Individuals Served
0-15 Children/Youth	68	68	68
16-25 TAY	42	42	42
26-59 Adults	0	0	0
60+ Older Adults	0	0	0
Total	110	110	110
Contract amount	\$19,500	\$19,500	\$19,500
Cost per client	\$177.27	\$177.27	\$177.27

Outcome Highlights

FY 23–24 marked a year of growth and youth leadership for the CLARO/A Program. Over 60 youth participated actively each semester across school sites, with engagement increasing through student-led activities. The first-ever student-driven Mental Health Resource Fair at St. Helena High School was a major milestone, empowering students to take ownership of promoting wellness and reducing stigma.

Youth-led fairs and prevention activities reached over 150 students countywide through school events, outreach, and community fairs. Feedback surveys indicated that participants felt more confident discussing mental health, recognized available resources, and developed stronger communication skills. Mentors observed improvements in students' academic motivation, emotional regulation, and peer relationships.

Several CLARA and CLARO youth received recognition as CLARO/A Scholars, highlighting the program's impact on leadership development and long-term engagement. Additionally, staff completed Cognitive Behavioral Intervention for Trauma in Schools (CBITS) and Support for Students Exposed to Trauma (SSET) training, enhancing their capacity to address trauma and stress among participants.

Challenges and Adaptations

The program experienced staffing challenges early in the fiscal year when the CLARO facilitator position became vacant, leading to a temporary reduction in direct mentoring for male participants. UVFC successfully filled this position in March 2024, onboarding a new Youth Program Coordinator who revitalized the CLARO component and supported joint CLARO/A projects.

To maintain program momentum during the transition, the CLARA mentor expanded her role to provide temporary mentoring to CLARO youth and collaborated with community partners to

sustain activities. UVFC also introduced peer mentoring opportunities for alumni to assist with events, enhancing continuity and leadership development.

The program continues to adapt to changing school dynamics and community needs by integrating trauma-informed practices, expanding family engagement, and increasing bilingual outreach to ensure equitable access for all Up Valley youth.

Prevention Program Name:

Up Valley Family Centers (UVFC) - Senior Wellness

Target Population

The UVFC Senior Wellness Program serves older adults aged 60 and above living in Napa County's Up Valley region, including Calistoga, St. Helena, and nearby rural communities. The program primarily supports Latino older adults who experience barriers related to language, culture, transportation, and access to behavioral-health or social services. These challenges often increase the risk of social isolation, depression, and reduced engagement in community life. To address these needs, UVFC provides bilingual, culturally responsive services in trusted community settings such as senior housing sites, mobile-home parks, and local community centers. An intergenerational component connects older adults with youth volunteers, encouraging mentorship, cultural exchange, and mutual support.

Program Description and Goals

The Senior Wellness Program is a community-based prevention initiative designed to enhance the mental, physical, and social well-being of older adults through proactive engagement, education, and opportunities for connection. The program reduces loneliness and isolation—key risk factors for depression and health decline—by helping participants stay active, socially connected, and informed about available resources.

Program Goals:

- Increase social connection and community engagement among older adults.
- Promote healthy lifestyles through physical activity, education, and nutrition.
- Reduce the risk of depression and isolation among Latino seniors.
- Build cross-generational relationships through shared cultural and educational experiences.
- Improve awareness of and access to available health, mental-health, and social-service supports.

Key Activities and Services

During FY 23–24, UVFC implemented a wide range of outreach, wellness, and educational services supporting both individual and community-level prevention.

Outreach and Engagement:

Program staff delivered multiple presentations and attended community events across Up Valley, including health fairs, fire-department outreach, and local radio segments. Through these efforts, UVFC reached approximately 639 individuals, increasing awareness of senior-focused behavioral-health and wellness resources. Two Senior Services Open Houses and a Senior Health Fair were hosted in Calistoga and St. Helena, each attracting strong participation.

Case Management and Linkages:

UVFC provided individualized case management to 262 seniors, assisting with benefits applications, housing navigation, transportation, and referrals to behavioral-health and social-service programs. These supports helped older adults maintain stability and improved access to needed care.

Cross-Generational Latino Men's Wellness Group:

A culturally focused Latino Men's Group engaged 10 older Latino men and 4 youth participants in bi-monthly sessions combining education, recreation, and peer connection. Sessions addressed topics such as mental-health awareness, technology use, financial literacy, and community resources. Participants also participated in group outings that fostered reflection, connection, and mutual support. All active members reported feeling more connected and less isolated.

Line Dancing and Nutrition Education:

The program hosted 19 line-dancing and nutrition classes at community sites, reaching 53 participants. Using evidence-based materials from *Blue Zones Project* and other wellness initiatives, classes combined physical activity with healthy-eating education. Participants consistently reported improved mood, mobility, and social connection, with several continuing to meet informally after sessions concluded.

Client Demographics and Service Volumes (FY 23–24)

- Older adults receiving case management/linkages: 262
- Individuals reached through outreach and engagement: 639
- Participants in line-dancing and nutrition classes: 53
- Participants in Latino Men's Group: 10 men and 4 youth

The majority of participants were Latino and Spanish-speaking seniors living in rural Up Valley communities.

Estimated individuals served and cost per client:

Age	FY 23-24 Individuals Served	FY 24-25 Projected Individuals Served	FY 25-26 Projected Individuals Served
0-15 Children/Youth			
16-25 TAY			
26-59 Adults	377	1	1
60+ Older Adults	262	9	9
Total	639	4,813	4,813
Contract amount	\$129,000	\$80,000	\$80,000
Cost per client	\$133.26	\$17	\$17

Outcome Highlights

The Senior Wellness Program demonstrated significant impact in reducing isolation and increasing engagement among older adults. Participants reported stronger connections with peers, greater awareness of available services, and improved access to support networks.

Key outcomes included:

- 100 percent of Latino Men's Group participants reported increased social connection and reduced isolation.
- Expanded partnerships improved referral systems for seniors requiring behavioral-health or case-management support.
- Volunteer-led classes maintained continuity of activities despite staffing changes.
- Participants reported enhanced emotional well-being, confidence, and sense of belonging through consistent participation.

Collectively, these outcomes highlight the program's effectiveness in promoting wellness, building social networks, and fostering resilience among older adults across Napa County's Up Valley region.

Challenges and Adaptations

UVFC faced challenges related to staff vacancies and volunteer turnover, which temporarily affected continuity of programming. Recruitment delays for group facilitators and the loss of a volunteer instructor impacted participation early in the year. In response, UVFC recruited new volunteers, consolidated classes at high-attendance sites, and leveraged community partnerships to sustain key activities.

Despite these challenges, the program successfully maintained strong engagement and demonstrated flexibility in meeting the evolving needs of older adults. Its bilingual, community-

based approach continues to strengthen prevention efforts and promote wellness among Napa County's senior population.

Early Intervention Programs

Napa County's **early intervention programs** are designed to provide support at the first signs of mental health challenges. The **Napa County Office of Education (NCOE) Court and Community Schools SAP Program** offers targeted services to youth involved in the juvenile justice or alternative education systems, while the **Mentis Healthy Minds Healthy Aging Program** supports older adults experiencing early signs of depression or anxiety, helping them maintain independence and quality of life.

Early Intervention Program Name:

Napa County Office of Education (NCOE) - Court and Community Schools Student Assistance Program

Target Population

The Court and Community Schools (CCS) Student Assistance Program (SAP) serves middle and high school students who have been expelled, referred by their school district, or placed through the juvenile court system. These youth often face multiple barriers, including exposure to trauma, family instability, behavioral challenges, and disrupted education. Many come from under-resourced or marginalized communities and are at high risk for academic disengagement, substance use, or contact with the justice system.

The program prioritizes children and transition-age youth (ages 12–25) who attend non-traditional school settings where behavioral-health needs are high and access to mental-health care is historically low. Services are culturally and linguistically responsive, ensuring equitable access for Latino and bilingual students who comprise a significant portion of the CCS population.

Program Description and Goals

The Student Assistance Program (SAP) provides school-based prevention and early-intervention behavioral-health services within Napa County's Court and Community Schools. The program embeds licensed social workers and Intervention Coordinators directly on school campuses to ensure students can access help in safe, familiar, and non-stigmatizing environments.

Students receive support through individual counseling, group sessions, case management, and referrals to community-based mental-health services when higher levels of care are needed. SAP staff use evidence-based screening tools and collaborate closely with educators, probation officers, and behavioral-health providers to ensure continuity of care and consistent follow-up.

Program Goals:

- Identify early signs of mental-health concerns through universal screening.
- Increase access to behavioral-health and support services for high-risk youth.
- Reduce barriers to care by providing services directly within school settings.
- Strengthen coping skills, self-regulation, and school engagement.
- Improve collaboration among education, probation, and mental-health systems to support holistic student well-being.

Key Activities and Services

The SAP operates as an integrated prevention and early-intervention model within Napa County's Court and Community Schools network.

Behavioral-Health Screening:

All students complete the Patient Health Questionnaire (PHQ-9) during enrollment to assess depressive symptoms and identify students in need of early intervention. Screening data help guide individualized care planning and referrals to mental-health professionals when appropriate.

Individualized Support and Case Management:

Social workers and Intervention Coordinators provide ongoing one-on-one counseling, behavioral support, and skill-building interventions. These sessions focus on developing healthy coping mechanisms, improving attendance, and reducing behavioral incidents.

Group Services and Prevention Workshops:

Students participate in small-group sessions addressing stress management, substance-use prevention, self-esteem, and emotional regulation. Activities are designed to promote positive peer relationships, enhance communication, and build resilience.

Community Referrals and Coordination:

The program maintains partnerships with Mentis, Aldea, Stanford Sierra Youth & Families, and the Student Behavioral Health Incentive Program (SBHIP). Through these partnerships, SAP ensures timely referrals and service linkage for students needing ongoing therapy or specialized behavioral-health care.

Cross-System Collaboration:

NCOE collaborates with Napa County Probation, Behavioral Health, and school district administrators to align behavioral-health and educational goals, ensuring that students transitioning between systems receive consistent support and follow-up.

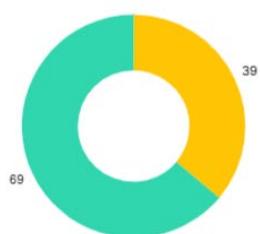
Client Demographics and Service Volumes (FY 23-24)

In FY 23-24, the SAP served 108 unique students across Court and Community School sites.

Total Clients Served:

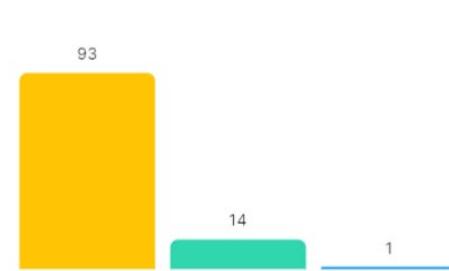
108

Age

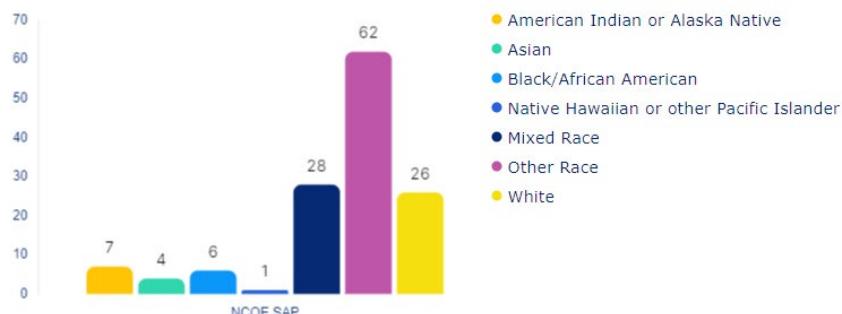


● Children/Youth (0-15) ● Transition Age Youth (16-25)

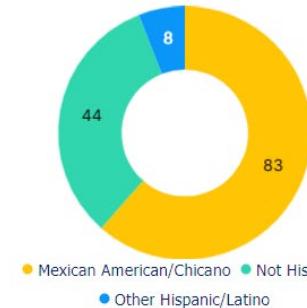
Language



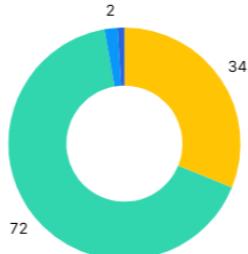
Race



Ethnicity

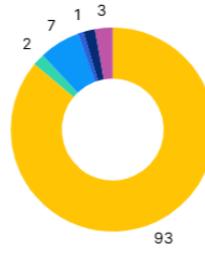


Gender

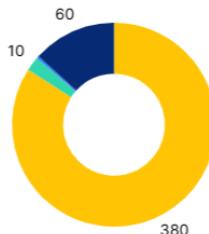


● Female ● Male ● Gender Queer ● Transgender

Sexual Orientation



Disability



● Mental (excluding: Mental Illness) ● Difficulty Seeing ● Difficulty Hearing
● Other ● No Disability

Estimated individuals served and cost per client:

Age	FY 23-24 Individuals Served	FY 24-25 Projected Individuals Served	FY 25-26 Projected Individuals To Be Served
0-15 Children/Youth	39	48	48
16-25 TAY	69	65	65
26-59 Adults	0	0	0
60+ Older Adults	0	0	0
Total	108	113	113
Contract amount	\$80,000	\$80,000	\$80,000
Cost per client	\$740.74	\$707.96	\$707.96

Outcome Highlights

The Student Assistance Program demonstrated strong performance in early identification and intervention for students experiencing emotional distress, anxiety, and depressive symptoms.

- 100% of students were screened using the PHQ-9 depression assessment tool.
- Over 1,500 services were delivered, including individual and group counseling, prevention education, and referrals.
- 46 students were linked to external behavioral-health providers for continued treatment.
- Staff reported noticeable improvements in attendance, class participation, and peer interactions among students engaged in ongoing counseling.
- Many students demonstrated increased self-awareness and willingness to seek help for emotional or behavioral concerns.

These outcomes underscore the program's effectiveness in reducing barriers to behavioral-health care, improving student well-being, and supporting re-engagement in school for at-risk youth.

Challenges and Adaptations

High student turnover and short enrollment durations presented challenges to providing continuous care. Many students transitioned in and out of the program within weeks, requiring rapid engagement and flexible service delivery.

To address these challenges, SAP staff implemented telehealth and hybrid counseling options to maintain contact with students after transitions. Staff also received training in trauma-informed care and restorative practices, enhancing their ability to work effectively with youth affected by trauma, instability, or disciplinary histories.

Ongoing collaboration with probation officers, behavioral-health providers, and community agencies has helped strengthen referral systems, ensure warm handoffs, and expand access to culturally competent services for students and families.

Early Intervention Program Name:

Mentis Healthy Minds Healthy Aging (HMHA)

Target Population

The Healthy Minds Healthy Aging (HMHA) program serves older adults aged 60 and over, along with their caregivers, who face barriers to accessing behavioral health care. This includes individuals who are low-income, homebound, or living with chronic health conditions, disabilities, or mobility challenges. Many reside in rural or Up Valley communities and are **monolingual Spanish speakers**. HMHA ensures equity and inclusion by offering bilingual, culturally responsive services that promote wellness, prevent depression, and support engagement across Napa County.

Program Description and Goals

HMHA is a community-based prevention and early intervention program designed to improve the emotional health, resilience, and quality of life of older adults. The program is led by Mentis and delivered in partnership with Collabria Care and Napa County Comprehensive Services for Older Adults, ensuring a coordinated approach to mental health, dementia care, and case management.

HMHA provides a continuum of care that includes screening, case management, peer outreach, and brief mental health treatment. Services are offered in-home, via telehealth, and in trusted community settings such as senior centers and faith-based locations to reach those who may otherwise be isolated or unable to access care.

Program Goals:

- Reduce isolation and increase social connectedness among older adults.
- Decrease symptoms of depression and anxiety.
- Improve daily functioning and overall quality of life.
- Increase accessibility and affordability of behavioral health care through free, bilingual services.
- Provide services in trusted, community-based settings and through telehealth or home visits as needed.

Key Activities and Services

The program provides a range of integrated prevention and early intervention services to support emotional well-being and social engagement among older adults.

Screening and Assessment:

HMHA utilizes evidence-based screening tools to assess mental health and cognitive functioning, including the PHQ-9, GAD-7, SF-12v2, and Columbia Suicide Severity Rating Scale (C-SSRS). These tools identify early signs of depression, anxiety, and cognitive decline to guide individualized care planning.

Case Management and Coaching:

Through the Program to Encourage Active, Rewarding Lives (PEARLS) model, bilingual case managers help clients set personal goals, manage symptoms, and stay connected to community supports. Staff assist clients in accessing medical care, housing, nutrition, and transportation resources to improve overall stability.

Therapy and Counseling:

HMHA offers brief treatment therapy for mild-to-moderate mental health concerns, provided by licensed clinicians in English and Spanish. Sessions are delivered in the home, via telehealth, or at community sites, emphasizing cognitive-behavioral techniques, mindfulness, and emotional regulation.

Social Connectedness and Peer Support:

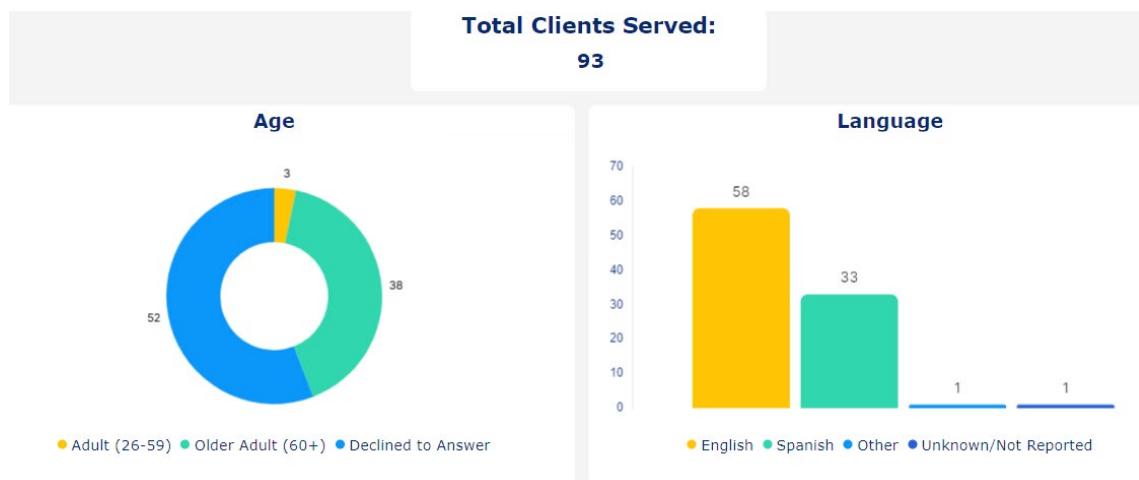
Peer Ambassadors—many of whom are former program participants—lead Wellness Cafés, bilingual support groups, and social engagement activities that promote inclusion and reduce loneliness. These activities encourage active aging, build confidence, and foster purpose through community involvement.

Community Outreach:

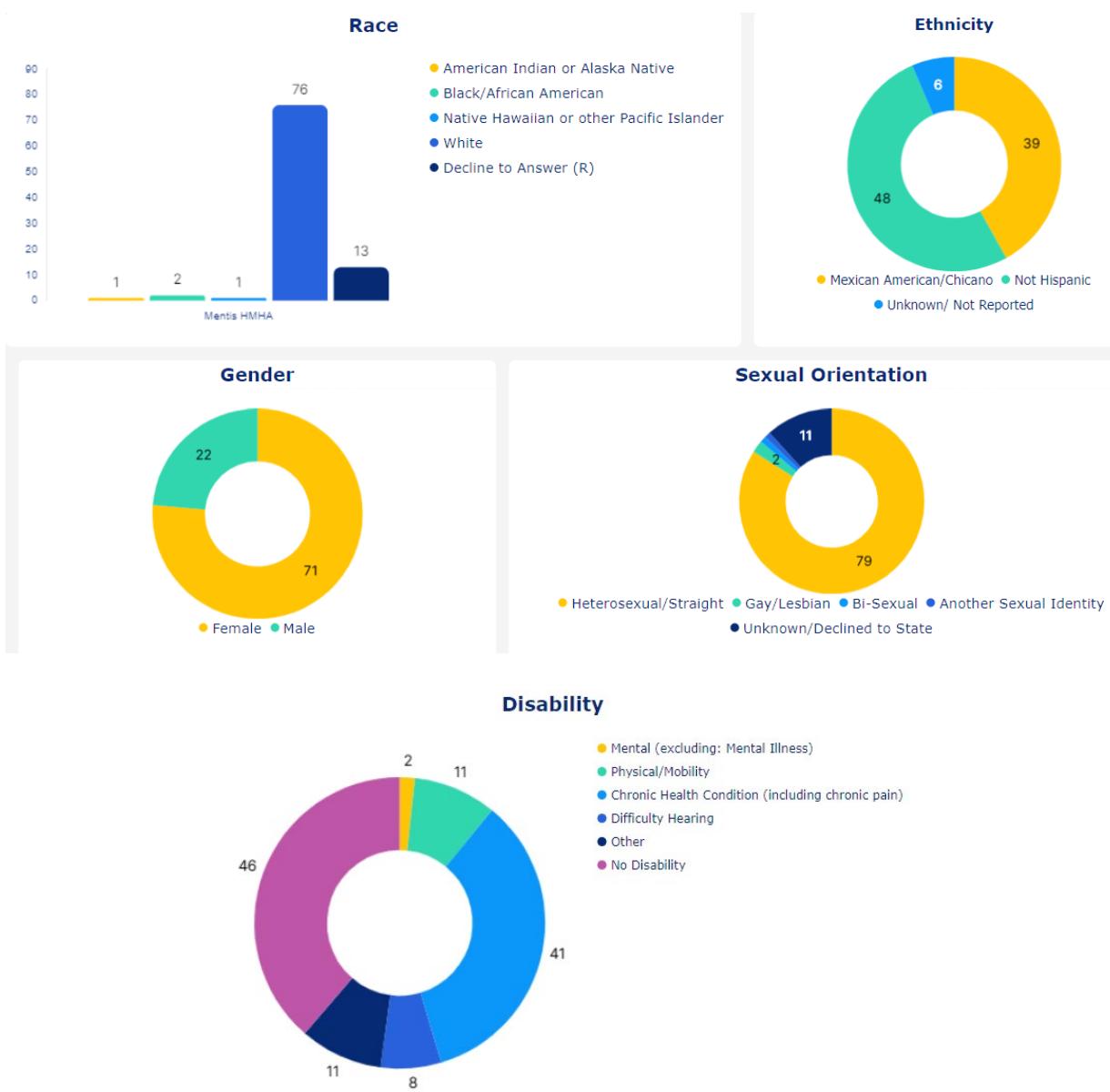
HMHA staff conduct bilingual outreach throughout Napa County, offering mental health education, presentations, and community events at senior housing sites, faith-based institutions, and cultural centers. Outreach efforts reduce stigma and connect older adults to appropriate services.

Client Demographics and Service Volumes (FY 23–24)

In FY 23–24, the HMHA program served **93 older adults** countywide.



Napa County MHSA FY 25-26 to Three Year Plan for FY 23-24 to FY 25-26



Estimated individuals served and cost per client:

Age	FY 23-24 Individuals Served	FY 24-25 Projected Individuals Served	FY 25-26 Program Terminated on 6/30/25
0-15 Children/Youth			
16-25 TAY			
26-59 Adult	55	8	
60+ Older Adult	38	89	
Total	93	97	
Contract amount	\$200,000	\$200,000	
Cost per client	\$2,150.54	\$2,061.86	

Outcome Highlights

HMHA participants demonstrated significant improvements in mental health and well-being during FY 23–24. Among those completing pre- and post-assessments, more than 80% showed measurable improvement in depression and anxiety scores. Clients reported feeling more engaged, supported, and confident in managing their mental health.

The Senior Ambassador Program was a highlight of the year, empowering older adults to lead community activities, advocate for their peers, and introduce new learning opportunities—such as bilingual classes and social gatherings—to reduce isolation.

Community outreach expanded considerably, with bilingual workshops and events reaching hundreds of older adults across Napa County. These efforts helped normalize conversations about mental health and improved early identification of depression and anxiety among underserved seniors.

Challenges and Adaptations

The program faced staffing transitions early in the fiscal year, including therapist turnover and delayed hiring for the bilingual case manager and outreach positions. These challenges were resolved mid-year, allowing services to return to full capacity.

HMHA also adapted to changing client needs as more seniors requested in-person therapy after years of pandemic-related telehealth. The program increased in-person availability while maintaining hybrid service options for homebound clients.

Looking forward, HMHA will continue strengthening outreach to Up Valley communities and collaborating with county and nonprofit partners to ensure accessible, culturally responsive mental health services for all older adults in Napa County.

Stigma and Discrimination Reduction

Efforts to reduce stigma and discrimination are also central to Napa County's PEI strategy. The **LGBTQ Connection program**, operated by **On The Move**, creates safe, affirming spaces for LGBTQ+ individuals and provides education and advocacy to reduce bias and discrimination across the community. This work not only supports mental health directly but also fosters inclusion and community resilience.

Stigma and Discrimination Reduction Program Name:

On The Move - LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer) Connection

Target Population

The LGBTQ Connection program serves families of LGBTQ+ children and youth, with a strong focus on Latine families and Spanish-speaking households. The program also reaches educators, school staff, mental health professionals, and community providers who work with LGBTQ+ individuals. The Rise for Napa initiative specifically prioritizes underserved areas such as American Canyon and Up Valley, where culturally competent LGBTQ+ education and support are limited.

Program Description and Goals

The LGBTQ Connection: Rise for Napa Program is a Prevention and Early Intervention (PEI) initiative addressing stigma and discrimination that affect how LGBTQ+ individuals are screened, assessed, and referred for mental health care. Using the RISE (Recognize, Intervene, Support, Empower) model—an evidence-based framework for fostering inclusion—the program empowers families, educators, and community organizations to create safer, affirming environments for LGBTQ+ youth.

Through bilingual education, training, and community partnerships, the program reduces isolation, promotes understanding, and strengthens family and community support systems for LGBTQ+ individuals across Napa County.

Program Goals:

- Deliver bilingual training and education to expand awareness and support for LGBTQ+ youth and families.
- Reduce stigma and discrimination through outreach and inclusion initiatives.
- Engage parents and caregivers in family acceptance education to improve mental health outcomes for LGBTQ+ youth.
- Provide technical assistance and consultation to schools, providers, and agencies to enhance inclusivity.
- Increase visibility and belonging for LGBTQ+ residents through community events and outreach campaigns.

Key Activities and Services

During FY 23–24, LGBTQ Connection implemented the Rise for Napa Program through direct education, training, and outreach activities that addressed stigma and improved community inclusion.

Training and Technical Assistance:

The program conducted six bilingual trainings for professionals, educators, and service providers, exceeding the annual goal of 100 participants with a total of 130 trainees. Topics included family acceptance, gender diversity, inclusive communication, and the intersection of culture and

identity. Post-training evaluations showed that 95% of participants reported increased knowledge and readiness to implement inclusive practices.

Family Engagement and Support:

Through outreach and collaboration with community partners, the program **reached 1,353 parents, caregivers, and family members with bilingual materials on family acceptance** and LGBTQ+ inclusion. While only one caregiver attended a specialized RISE parent workshop, feedback highlighted strong interest in additional Spanish-language sessions in future cycles.

Inclusive School Environments:

LGBTQ Connection worked with local schools to design and distribute inclusion symbols and visual cues, such as stickers, posters, and banners promoting safe spaces for LGBTQ+ youth. Each participating school received an average of four inclusion symbols, exceeding the annual target.

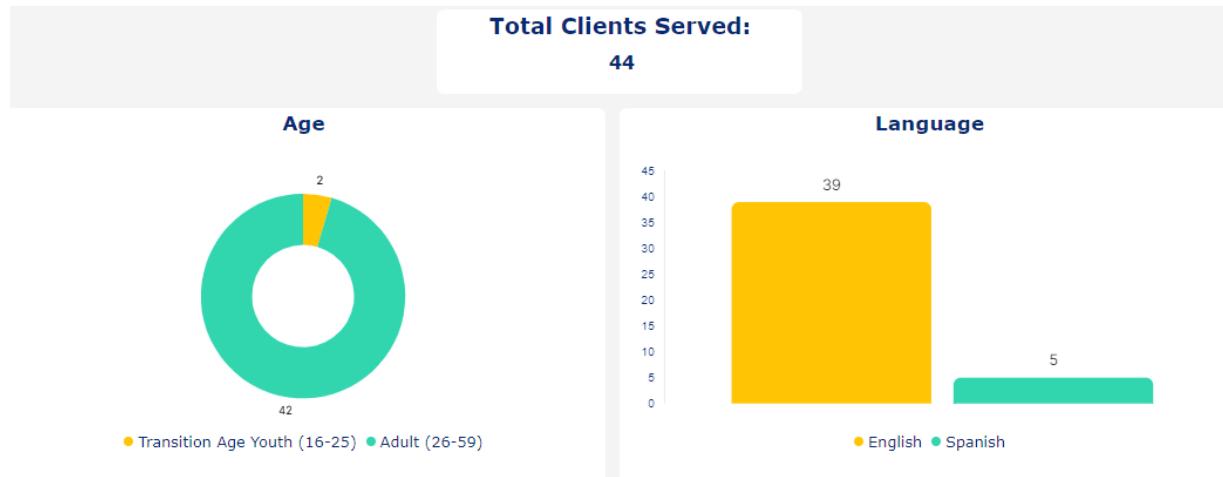
Community Partnerships:

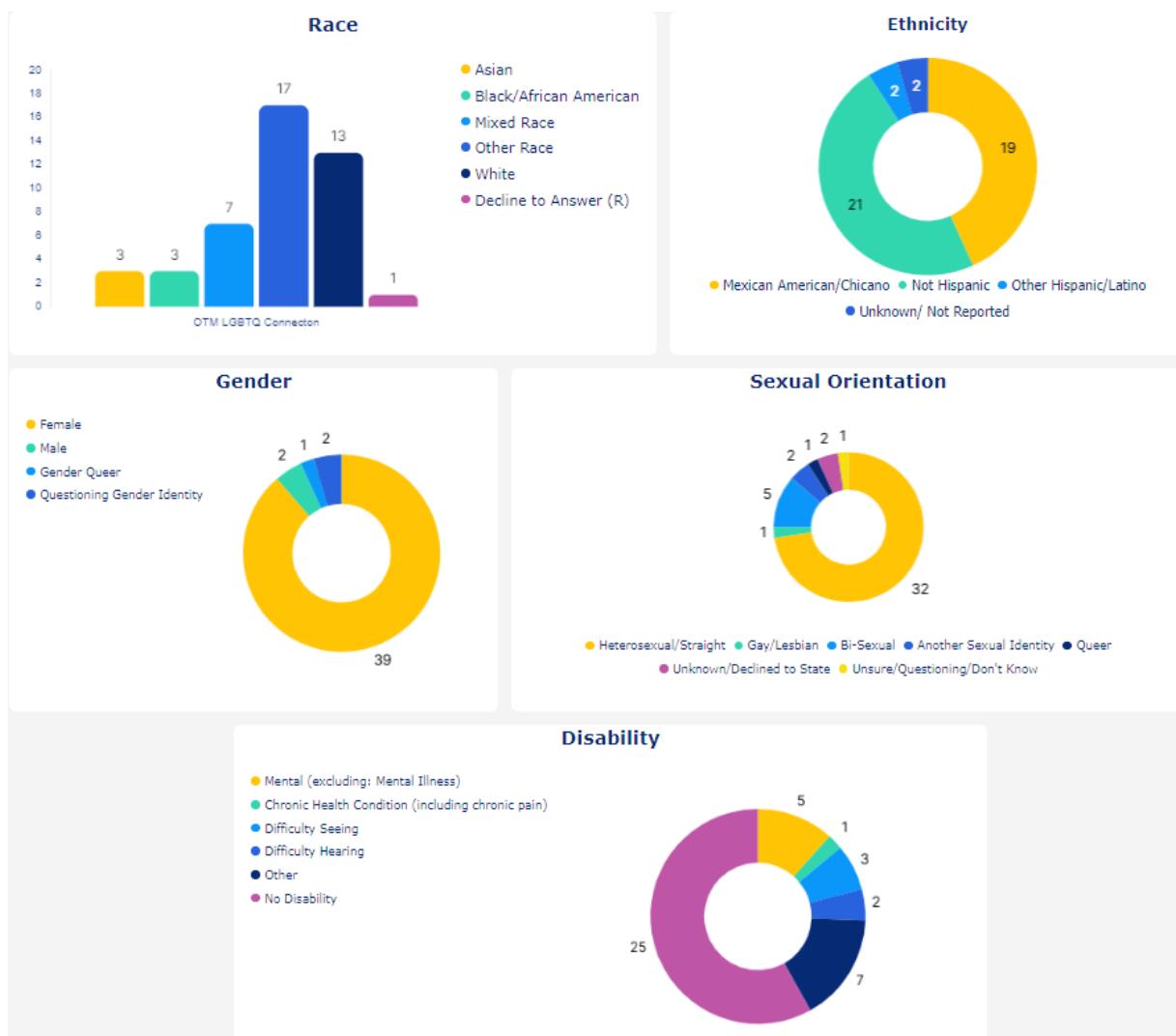
Collaborations with ParentsCAN, Aldea, COPE, UpValley Family Centers, and other local agencies were strengthened to enhance outreach and cross-referrals. These partnerships also supported recruitment for training participants and helped expand community engagement beyond central Napa.

Client Demographics and Service Volumes (FY 23–24)

In FY 23–24, LGBTQ Connection served 44 individuals directly and reached 1,353 additional community members through family outreach and education. Demographic information was collected only for those individuals who received direct services.

Demographics





Estimated individuals served and cost per client:

Age	FY 23-24 Individuals Served	FY 24-25 Contract Terminated at Request of Contractor	FY 25-26 Contract Terminated at Request of Contractor
0-15 Children/Youth	0		
16-25 TAY	42		
26-59 Adult	2		
60+ Older Adult	0		
Total	44		
Contract amount	\$90,000		
Cost per client	\$2,045.45		

Outcome Highlights

The Rise for Napa program achieved strong results in reducing stigma and improving community inclusion for LGBTQ+ residents in Napa County.

- **95% of trainees** reported increased understanding and confidence in implementing inclusive practices.
- **1,353 family members** received bilingual outreach and educational materials on LGBTQ+ family acceptance.
- **Inclusion symbols** were distributed across multiple schools, improving visibility and signaling safety for LGBTQ+ youth.
- **Community partnerships** expanded, strengthening collaboration among education, health, and social service systems.

These outcomes demonstrate the program's effectiveness in fostering belonging, promoting equitable treatment, and building a more inclusive environment for LGBTQ+ individuals and families.

Challenges and Adaptations

Staff transitions impacted program capacity early in the fiscal year, particularly following the departure of the RISE Program Coordinator. Despite this, the team maintained outreach, delivered all planned trainings, and met or exceeded most targets.

Moving forward, LGBTQ Connection plans to expand bilingual staff capacity, offer additional parent-focused sessions, and continue supporting local schools and agencies with inclusive training and resources to sustain Napa County's commitment to equity and inclusion.

As the LGBTQ Connection program continues to expand its reach, the lessons learned from these challenges and adaptations reflect a shared commitment across Napa County's PEI partners—to listen, evolve, and strengthen community-centered approaches. Collectively, these efforts reinforce the overarching goals of Prevention and Early Intervention: fostering inclusion, resilience, and early access to support for all Napa County residents.

Napa County's Prevention and Early Intervention (PEI) programs continue to play a vital role in building a healthier, more connected community. Through collaboration with local partners, culturally responsive outreach, and evidence-based approaches, these programs promote wellness across all ages—reducing stigma, strengthening protective factors, and addressing mental health concerns before they escalate into crises. From expanding school-based supports and youth mentorship to increasing access for older adults and fostering inclusion for LGBTQ+ residents, Napa County's PEI initiatives embody the spirit of early action and community partnership. Collectively, they advance the County's commitment to health equity, prevention,

and the creation of a resilient, inclusive system of care that supports the mental well-being of all Napa County residents.

Statewide MHSA Prevention and Early Intervention Strategies – CalMHSA

Through a partnership with the California Mental Health Services Authority (CalMHSA), a Joint Powers Authority established to implement statewide MHSA Prevention and Early Intervention (PEI) strategies, Napa County Behavioral Health contributes funding to the Statewide PEI Program.

In FY 23–24, CalMHSA’s *Take Action for Mental Health* campaign continued to promote mental wellness, reduce stigma, and prevent suicide through public awareness, education, and outreach efforts. The campaign focused on three pillars—Check In, Learn More, and Get Support—and emphasized inclusion and equity across communities.

Statewide activities included targeted campaigns for Juneteenth, Pride Month, and Transgender Day of Remembrance; youth engagement through social media and the Directing Change Program; and dissemination of seasonal toolkits for Suicide Prevention Week, Winter Wellness, and Mental Health Matters Month. Statewide media and outreach efforts have reached millions of Californians and provided accessible, culturally responsive mental health resources that support local PEI efforts.

A detailed summary of CalMHSA’s FY 23–24 statewide Prevention and Early Intervention outcomes is provided in Appendix 3.

Innovation (INN)

Learning Health Care Network for Early Psychosis

During FY 2023-24, Napa County Behavioral Health continued participation in the statewide Early Psychosis Learning Health Care Network (LHCN), led by the University of California, Davis, in collaboration with UC San Francisco, UC San Diego, and multiple California counties. The LHCN is part of California's EPI-CAL regional hub within the national Early Psychosis Intervention Network (EPINET) and is designed to enhance early identification, clinical outcomes, and system learning through shared data, clinician dashboards, and collaborative evaluation.

Napa County contributed de-identified data from its early psychosis programs, consistent with Institutional Review Board (IRB) approval and HIPAA-compliant data transfer protocols, to support statewide analyses of service access, outcomes, and cost. County staff participated in planning, data refinement, and coordination meetings led by UC Davis.

The Data Transfer and Use Agreement between Napa County and UC Davis concluded on June 30, 2024, marking the end of the current phase of the Learning Health Care Network project. Any continuation of this work will depend on renewal of the statewide partnership or the initiation of a successor effort.

MHSOAC Multi-County FSP Collaborative

Napa County continued participation in the Multi-County Full-Service Partnership (FSP) Collaborative administered by the California Mental Health Services Authority (CalMHSA) and implemented by Third Sector Capital Partners. The project seeks to improve outcome measurement, data quality, and consistency across county FSP programs through shared learning and evaluation.

In FY 2023-24, Napa County participated in the Implementation Phase, contributing to the development of shared outcome and discharge definitions, sustainability planning, and statewide evaluation design. Third Sector convened regular workgroup meetings and facilitated collaboration among participating counties.

The CalMHSA Participation Agreement for this project extends through July 31, 2025, at which point the Multi-County FSP Collaborative is scheduled to conclude following completion of the sustainability and final evaluation phases.

INN Administration

Administrative activities supported Napa County's participation in both statewide Innovation projects, including coordination with CalMHSA, UC Davis, and partner counties.

Planned Activities for FY 2024-25

In FY 2024-25, Napa County Behavioral Health will continue participation in the final phase of the Multi-County FSP Collaborative and monitor developments related to future statewide Early Psychosis initiatives. Napa County will also initiate a new Innovation project, **PIVOT**, modeled after Orange County's approved plan, to enhance coordination and outcomes for individuals with complex behavioral health needs.

Workforce Education and Training (WET)

Napa County entered into a Participation Agreement (PA) with CalMHSA in FY 2023–2024 to implement workforce development programs funded through the WET component. This agreement supported the County’s participation in the Greater Bay Area Regional Partnership (GBA RP), established under the State’s 2020–2025 WET Five-Year Plan. Under this PA, CalMHSA served as the fiscal and administrative agent, responsible for overseeing application review, eligibility verification, award disbursement, and data reporting for eligible WET programs.

Through this partnership, Napa County participated in both the Loan Repayment Program and the Graduate Education Stipend Program, which were designed to support the recruitment and retention of behavioral health professionals in the public mental health system. According to the CalMHSA WET Dashboard, a total of 32 individuals received awards through these programs between FY 23/24 and FY 24/25. Award amounts ranged from \$5,000 to \$20,000. Recipients included both licensed behavioral health providers and clinical graduate students preparing to enter the workforce. Award periods ranged from September 1, 2023, to June 30, 2025, aligning with the closeout of the WET Five-Year Plan.

Capital Facilities/Technological Needs (CF/TN)

Overview

The Capital Facilities and Technological Needs (CF/TN) component of the Mental Health Services Act (MHSA) supports Napa County Health and Human Services Agency – Behavioral Health Division in developing the infrastructure necessary to deliver accessible, high-quality, and integrated behavioral health care. In FY 2023–24, Napa County advanced two primary initiatives: planning and design for a children’s behavioral health Crisis Stabilization Unit (CSU) expansion and continued implementation of the County’s new Electronic Health Record (EHR) system, SmartCare.

Capital Facilities Project – Children’s CSS Expansion (Crisis Stabilization Unit)

During FY 2023–24, Napa County completed design, engineering, and permitting for the expansion of the children’s and youth Crisis Stabilization Unit (CSU) located at 2751 Napa Valley Corporate Drive. The project will expand CSU capacity and create a modern, developmentally appropriate environment for children, youth, and families in crisis.

The project broke ground in early FY 2025–26, initiating construction on an expanded facility that will increase stabilization bed capacity, add family and sensory rooms, and incorporate trauma-informed design elements to support safety, privacy, and comfort.

This expansion represents a major milestone in Napa County's efforts to strengthen the behavioral health continuum of care for children and youth and aligns with MHSA Capital Facilities goals by improving access to timely crisis services in a trauma-informed setting.

Technological Needs Project – Electronic Health Record (EHR) Implementation (SmartCare)

In FY 2023–24, Napa County continued preparations for implementation of **SmartCare**, a new electronic health record system that will replace the County's legacy Credible platform. SmartCare will provide a unified, modernized system for clinical documentation, billing, and reporting, and will improve coordination across behavioral health and substance use disorder services.

Key activities during FY 2023–24 included:

- Mapping and preparing data for migration from Credible to SmartCare.
- Designing clinical documentation and billing workflows.
- Participating in statewide configuration and testing workgroups.
- Developing user roles, access permissions, and system security.
- Planning county-wide training and go-live readiness.

SmartCare implementation supports Napa County's commitment to enhancing data quality, compliance, and performance monitoring. The project remains on schedule for go-live in October 2025.

Administration/Indirect Costs

CFTN funds also supported administrative functions necessary to manage the planning, procurement, and oversight of both capital and technology projects. Activities included contract administration, coordination with architects and vendors, fiscal tracking, and project reporting.

Planned Activities for FY 2024–25 and FY 2025–26

- **Children's CSU Expansion:** Move from pre-construction into active construction (underway in FY 2025–26) with anticipated completion in FY 2025–26.
- **EHR (SmartCare):** Complete implementation and transition to post-go-live optimization and user support following the October 2025 go-live.
- Maintain project oversight, fiscal management, and reporting to ensure successful completion of both projects in alignment with MHSA goals.

MHSA Funding Summaries and Component Funding for FY 23-24 to FY 25-26

FY 2023-24 Mental Health Services Act Three-Year Plan
Funding Summary

County: Napa _____

Date: 9/5/25

	MHSA Funding					
	A	B	C	D	E	F
Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve	
A. FY 2023-24 Funding						
1. Unspent Funds from Prior Fiscal Years	13,671,831	2,488,888	1,646,556	3,332	-	
2. Prior Year Reversion				-		
3. New FY 2023/24 Funding*	8,764,092	2,191,023	576,585	-	-	
4. Transfer in FY 2023/24	(480,920)			150,648	330,273	
5. Access Local Prudent Reserve in FY 2023/24	-	-				
6. Re-distributed Reversion Funds						
7. Available Funding for FY 2023/24	21,955,003	4,679,911	2,223,141	153,980	330,273	
B. FY 2023/24 MHSA Expenditures	6,512,546	2,906,749	304,783	153,980	330,273	
G. FY 2023/24 Unspent Fund Balance	15,442,456	1,773,162	1,918,358	-	-	

*Includes the planned No Place Like Home Initiative reduction estimate of \$313,672 for CSS and \$137,847 for PEI

H. Local Prudent Reserve Balance		
1. Local Prudent Reserve Balance on June 30, 2023		764,402
2. Contributions to the Local Prudent Reserve in FY 2023/24		0
3. Distributions from the Local Prudent Reserve in FY 2023/24		0
4. Local Prudent Reserve Balance on June 30, 2024		764,402

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

FY 23-24 CSS Funding

Mental Health Services Act (MHSA) Three Year Plan
Community Services and Supports (CSS) FundingCounty: NapaInitial Date: 8/30/23Revision Date: 9/5/25

	Fiscal Year 2023-24					
	A	B	C	D	E	F
	Total Mental Health Expenditures	CSS Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
FSP Programs						
1. Children's FSP	559,017	297,727	261,290	-	-	-
2. TAY FSP	768,883	463,478	305,405	-	-	-
3. Adult FSP	1,354,086	1,100,967	193,110	-	-	60,009
4. Adult Treatment Team FSP	931,474	750,919	180,555	-	-	-
5. Older Adult FSP	570,360	423,255	147,105	-	-	-
6.						
Non-FSP Programs						
1. Admin	510,855	254,420	256,435	-	-	-
2. Mobile Crisis Response Team	1,001,876	516,091	363,000	-	-	122,785
3. Project Access	524,361	504,506	19,855	-	-	-
5. Housing	-	-	-	-	-	-
6.						
CSS Annual Planning Costs	35,538	35,538				
CSS Administration (Indirect)	2,165,646	2,165,646				
CSS MHSA Housing Program Assigned Funds	-	-	-			
Total CSS Program Expenditures	8,422,095	6,512,546	1,726,755	-	-	182,794
FSP Programs as Percent of Total	64.2%					

FY 23-24 PEI Funding

Mental Health Services Act (MHSA) Three Year Plan
Prevention and Early Intervention (PEI) Funding

County: Napa

Initial Date: 8/30/23
Revision Date: 9/5/25

	Fiscal Year 2023-24					
	A Total Mental Health Expenditures	B PEI Funding	C Medi-Cal FFP	D 1991 Realignment	E Behavioral Health Subaccount	F Other Funding
Access & Linkage to Treatment Program						
1. NVEF American Canyon Mental Health Access Program	299,000	299,000				
Prevention Programs						
2. Aldea Supportive Outreach & Access to Resources	229,420	229,420				
3. COPE Strengthening Families At Risk PEI Program	139,388	139,388				
4. COPE Ready Set Grow	169,388	169,388				
5. Mentis Suicide Prevention	92,909	92,909				
6. Mentis Safety Net for Youth Mental Wellness Program	97,909	97,909				
7. Mentis Student Connect	115,449	115,449				
8. Mentis Bridges Community Mental Health Treatment	167,909	167,909				
9. Molly's Angels Program for Older Adults	102,441	102,441				
10. NEWS Kids Exposed to Domestic Violence	130,054	130,054				
11. NVEF Wellness Centers as Hubs for Access & Intervention	310,359	310,359				
12. On The Move Guaranteed Income for Foster Youth	136,667	136,667				
13. Up Valley Mentoring Program (CLARO/A)	98,894	98,894				
14. Up Valley Senior Wellness	122,476	122,476				
Early Intervention Programs						
15. NCOE Court and Community Schools SAP Program	80,000	80,000				
16. Mentis Healthy Minds Healthy Aging Program	217,909	217,909				
Stigma and Discrimination Reduction						
17. On The Move LGBTQ Connection	79,187	79,187				
PEI Administration (Indirect)	296,061	296,061				
PEI Annual Planning Costs	279	279				
PEI Expenditures Incurred by JPA	21,051	21,051				
Total PEI Program Expenditures	2,906,749	2,906,749	0	0	0	0

FY 23-24 INN Funding

Mental Health Services Act (MHSA) Three Year Plan
Innovations (INN) FundingCounty: NapaInitial Date: 8/30/23
Revision Date: 9/5/25

	Fiscal Year 2023-24					
	A	B	C	D	E	F
	Total Mental Health Expenditures	INN Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
INN Programs						
1. LHCN - Aldea	41,567	41,567	-			
2. LHCN - UC Davis	9,156	9,156	-			
3. MHSOAC FSP Collaborative Project	-	-				
4.						
INN Administration (Indirect)	31,046	31,046				
INN Expenditures Incurred by JPA	223,014	223,014				
Total INN Program Expenditures	304,783	304,783	-	-	-	-

FY 23-24 WET Funding

Mental Health Services Act (MHSA) Three Year Plan
Workforce, Education and Training (WET) Funding

County: NapaInitial Date: 8/30/23
 Revision Date: 9/5/25

	Fiscal Year 2023-24					
	A	B	C	D	E	F
	Total Mental Health Expenditures	WET Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
WET Programs 1. CalMHSA Greater Bay Regional Partnership 2. Training/Technical Assistance 3. 4. 5.	138,000 295	138,000 295				
WET Administration (Indirect)	15,685	15,685				
Total WET Program Expenditures	153,980	153,980		-	-	-

FY 23-24 CFTN Funding

Mental Health Services Act (MHSA) Three Year Plan
Capital Facilities/Technological Needs (CFTN) Funding

County: Napa

Initial Date: 8/30/23
Revision Date: 9/5/25

	Fiscal Year 2023-24					
	A	B	C	D	E	F
	Total Mental Health Expenditures	CFTN Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
CFTN Programs - Capital Facilities Projects						
1. Children CSS Expansion	277,964	277,964				
2.	-	-				
3.	-	-				
CFTN Programs - Technological Needs Projects						
4. Electronic Health Record Implementation	46,980	46,980				
5.	-	-				
6.	-	-				
CFTN Administration (Indirect)	5,328	5,328				
Total CFTN Program Expenditures	330,273	330,273		-	-	-

FY 24-25 MHSA Funding Summary

FY 2024-25 Mental Health Services Act Three-Year Plan
Funding Summary

County: Napa

Date: 9/5/25

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2024-25 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	15,394,765	1,773,162	1,918,358	-	-	
2. Estimated Prior Year Reversion	-	-	-	-	-	
3. Estimated New FY 2024/25 Funding*	9,178,354	2,294,588	603,839	-	-	
4. Transfer in FY 2024/25	(1,324,592)			28,609	1,295,983	-
5. Access Local Prudent Reserve in FY 2024/2025	-	-				-
6. Re-distributed Reversion Funds	-	-				-
7. Estimated Available Funding for FY 2024/2025	23,248,526	4,067,750	2,522,197	28,609	1,295,983	
B. Estimated FY 2024/25 MHSA Expenditures	7,175,220	2,939,032	100,646	28,609	1,295,983	
G. Estimated FY 2024/25 Unspent Fund Balance	16,073,306	1,128,718	2,421,551	-	-	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2024	764,402
2. Contributions to the Local Prudent Reserve in FY 2024/25	-
3. Distributions from the Local Prudent Reserve in FY 2024/25	-
4. Estimated Local Prudent Reserve Balance on June 30, 2025	764,402

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

FY 24-25 CSS Funding

**Mental Health Services Act (MHSA) Three Year Plan
Community Services and Supports (CSS) Funding**

County: Napa
 Initial Date: 8/30/23
 Revision Date: 9/5/25

	Fiscal Year 2024-25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Children's FSP	555,286	105,808	449,478			
2. TAY FSP	792,527	309,734	482,793			
3. Adult FSP	1,014,794	831,555	157,609			
4. Adult Treatment Team FSP	619,205	615,205	4,000			
5. Older Adult FSP	704,966	488,840	216,126			
6. CHFSP Expansion - High Fidelity Wrap	1,150,627	918,730	231,897			
						25,631
Non-FSP Programs						
1. Mobile Crisis Response Team	1,574,854	672,451	546,605			
2. Project Access	639,352	639,352				
3. Admin	631,389	497,389	134,000			
4. Community Planning Process	73,215	73,215				
5. System Development	450,057	450,057				
						355,797
CSS Administration (Indirect)	1,572,884	1,572,884				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	9,779,155	7,175,220	2,222,508	-	-	381,428
FSP Programs as Percent of Total	67.4%					

FY 24-25 PEI Funding

Mental Health Services Act (MHSA) Three Year Plan
Prevention and Early Intervention (PEI) Funding

County: Napa
 Initial Date: 8/30/23
 Revision Date: 9/5/25

	Fiscal Year 2024-25					
	A	B	C	D	E	F
Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding	
Access & Linkage to Treatment Programs						
1. NVEF American Canyon Mental Health Access Program	160,000	160,000				
2. NVEF American Canyon Middle School Access to MH	90,000	90,000				
3. Molly's Angels CARE Program	143,303	143,303				
Prevention Programs						
1. COPE Strengthening Families At Risk PEI Program	90,000	90,000				
2. COPE Ready Set Grow	120,000	120,000				
3. COPE Pathways to Family MH and Wellbeing	119,340	119,340				
4. Mentis Suicide Prevention	225,157	225,157				
5. Mentis Safety Net for Youth Mental Wellness Program	80,000	80,000				
6. Mentis Student Connect Napa Valley College	97,540	97,540				
7. Mentis Middle School Foundations of Wellness Program	154,804	154,804				
8. Up Valley Mentoring Program (CLARO/A)	80,000	80,000				
9. Up Valley Senior Wellness	117,152	117,152				
10. Napa County Triple P Collaborative	384,600	384,600				
11. Planned Parenthood Expanding Access	125,630	125,630				
12. ParentsCAN Parent Stress Reduction Program	66,733	66,733				
13. OTM Guaranteed Income for Foster Youth	78,709	78,709				
Early Intervention Programs						
1. Mentis Healthy Minds, Healthy Aging Program	200,000	200,000				
2. Court and Community Schools SAP Program	80,000	80,000				
PEI Administration (Indirect)	477,758	477,758				
PEI Assigned Funds - CalMHSA	48,000	48,307				
Total PEI Program Estimated Expenditures	2,939,032	2,939,032	-	-	-	-

FY 24-25 INN Funding

Mental Health Services Act (MHSA) Three Year Plan
Innovations (INN) Funding

County: NapaInitial Date: 8/30/23
 Revision Date: 9/5/25

	Fiscal Year 2024-25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. MHSOAC FSP Collaborative Project	83,567	83,567				
2. LHCN - UC Davis	718	718				
INN Administration	16,361	16,361				
Total INN Program Estimated Expenditures	100,646	100,646		-	-	-

FY 24-25 WET Funding

Mental Health Services Act (MHSA) Three Year Plan
Workforce, Education and Training (WET) Funding

County: Napa

Initial Date: 8/30/23
Revision Date: 9/5/25

	Fiscal Year 2024-25					
	A	B	C	D	E	F
Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding	
WET Programs						
1. CalMHSA Greater Bay Regional Partnership	-					
2. Napa County BH Workforce Development Strategies	23,958	23,958				
WET Administration	0	4,651				
Total WET Program Estimated Expenditures	23,958	28,609	-	-	-	-

FY 24-25 CFTN Funding

**Mental Health Services Act (MHSA) Three Year Plan
Capital Facilities/Technological Needs (CFTN) Funding**

County: Napa
 Initial Date: 8/30/23
 Revision Date: 9/5/25

	Fiscal Year 2024-25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects	-	-				
CFTN Programs - Technological Needs Projects 1. EHR Implementation	1,126,942	1,126,942				
CFTN Administration	169,041	169,041				
Total CFTN Program Estimated Expenditures	1,295,983	1,295,983	-	-	-	-

FY 25-26 MHSA Funding Summary

FY 2025-26 Mental Health Services Act Three-Year Plan
Funding Summary

County: Napa

Date: 9/5/25

	MHSA Funding					
	A Community Services and Supports	B Prevention and Early Intervention	C Innovation	D Workforce Education and Training	E Capital Facilities and Technological Needs	F Prudent Reserve
A. Estimated FY 2025-26 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	16,073,307	1,128,718	2,421,551	-	-	
2. Estimated Prior Year Reversion	-	-	-	-	-	
3. Estimated New FY 2025/26 Funding*	9,180,000	2,300,000	605,000	-	-	
4. Transfer in FY 2025/26	(1,896,416)	-		173,556	1,722,860	-
5. Access Local Prudent Reserve in FY 2025/26	-	-				-
6. Re-distributed Reversion Funds	-	-				-
7. Estimated Available Funding for FY 2025/26	23,356,891	3,428,718	3,026,551	173,556	1,722,860	
B. Estimated FY 2025/26 MHSA Expenditures	10,838,886	2,181,481	336,345	173,556	1,722,860	
G. Estimated FY 2025/26 Unspent Fund Balance	12,518,005	1,247,237	2,690,206	-	-	

*Includes the planned No Place Like Home Initiative reduction estimate of \$313,672 for CSS and \$137,847 for PEI

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2025	764,402
2. Contributions to the Local Prudent Reserve in FY 2025/26	0
3. Distributions from the Local Prudent Reserve in FY 2025/26	0
4. Estimated Local Prudent Reserve Balance on June 30, 2026	764,402

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

FY 25-26 CSS Funding

Mental Health Services Act (MHSA) Three Year Plan Community Services and Supports (CSS) Funding

County: Napa

Initial Date: 8/30/23
Revision Date: 9/5/25

	Fiscal Year 2025-26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Children's FSP	524,961	149,961	375,000			
2. TAY FSP	942,885	437,885	505,000			
3. Adult FSP	1,797,230	1,497,230	250,000			
4. Adult Treatment Team FSP	752,772	427,772	325,000			
5. Older Adult FSP	1,032,016	782,016	250,000			
6. CHFSP Expansion - High Fidelity Wrap	1,292,000	646,000	646,000			50,000
Non-FSP Programs						
1. Mobile Crisis Response Team	2,365,018	1,715,018	650,000			
2. Project Access	931,797	931,797				
3. Admin	1,430,125	1,280,125	150,000			
4. Community Planning Process	175,498	175,498				
5. System Development	509,600	509,600				
CSS Administration (Indirect)	2,285,984	2,285,984		-	-	
CSS MHSA Housing Program Assigned Funds	-	-	-	-	-	-
Total CSS Program Estimated Expenditures	14,039,886	10,838,886	3,151,000	-	-	50,000
FSP Programs as Percent of Total	37.1%					

FY 25-26 PEI Funding

Mental Health Services Act (MHSA) Three Year Plan
Prevention and Early Intervention (PEI) Funding

County: Napa

 Initial Date: 8/30/23
 Revision Date: 9/5/25

	Fiscal Year 2025-26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Access & Linkage to Treatment Program						
1. NVEF American Canyon Mental Health Access Program	160,000	160,000				
2. NVEF American Canyon Middle School Access to MH	90,000	90,000				
3. Molly's Angels CARE Program	144,000	144,000				
Prevention Programs						
1. COPE Strengthening Families At Risk PEI Program	90,000	90,000				
2. COPE Pathways to Family MH and Wellbeing	120,000	120,000				
3. Mentis Suicide Prevention	161,416	161,416				
4. Mentis Middle School Foundations of Wellness Program	162,544	162,544				
5. Up Valley Mentoring Program (CLARO/A)	80,000	80,000				
6. Up Valley Senior Wellness	137,200	137,200				
7. Napa County Triple P Collaborative	392,831	392,831				
8. Planned Parenthood Expanding Access	152,768	152,768				
9. ParentsCAN Parent Stress Reduction Program	66,733	66,733				
	-					
Early Intervention Programs						
1. Court and Community Schools SAP Program	80,000	80,000				
PEI Administration (Indirect)	295,489	295,489				
PEI Assigned Funds - CalMHSA	48,500	48,500				
Total PEI Program Estimated Expenditures	2,181,481	2,181,481	-	-	-	-

FY 25-26 INN Funding

Mental Health Services Act (MHSA) Three Year Plan
Innovations (INN) Funding

Initial Date: 8/30/23
 Revision Date: 9/5/25

County: Napa

	Fiscal Year 2025-26					
	A	B	C	D	E	F
Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding	
INN Programs						
1. PIVOT	290,380	290,380				
2.	-					
3.	-					
4.	-					
5.	-					
INN Administration (Indirect)	45,965	45,965				
Total INN Program Estimated Expenditures	336,345	336,345	-	-	-	-

FY 25-26 WET Funding

Mental Health Services Act (MHSA) Three Year Plan
Workforce, Education and Training (WET) Funding

County: Napa

Initial Date: 8/30/23
Revision Date: 9/5/25

	Fiscal Year 2025-26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. CalMHSA Greater Bay Regional Partnership	150,047	150,047				
2. Napa County BH Workforce Development S	-	-				
3.	-					
4.	-					
5.	-					
WET Administration (Indirect)	23,509	23,509				
Total WET Program Estimated Expenditures	173,556	173,556				

FY 25-26 CFTN Funding

**Mental Health Services Act (MHSA) Three Year Plan
Capital Facilities/Technological Needs (CFTN) Funding**

County: Napa
 Initial Date: 8/30/23
 Revision Date: 9/5/25

	Fiscal Year 2025-26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi- Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Hartle Court - Cal HFA	1,264,000	1,264,000				
CFTN Programs - Technological Needs Projects						
2. EHR Implementation	329,769	329,769				
CFTN Administration (Indirect)	129,091	129,091				
Total CFTN Program Estimated Expenditures	1,722,860	1,722,860		-	-	-

Appendix 1

Assessment of the County's Capacity to Implement Mental Health Programs and Services

MHSA Capacity Assessment Survey

Additionally, the BH Division developed a survey to assess the capacity of MHSA Contractors to implement their MHSA programs (Appendix 1). The survey has been distributed to these Community-Based Organizations and includes the following:

- A. The strengths and limitations of contracted service providers that impact their ability to meet the needs of racially and ethnically diverse populations.
- B. Service Providers' bilingual proficiency in identified threshold language – Spanish.
- C. Percentages of diverse cultural, racial/ethnic, and linguistic groups represented among direct service providers, as compared to percentage of the total population needing services and the total population currently being served.
- D. Identification of possible barriers to implementing the proposed programs/services and methods of addressing these barriers.

Napa County Mental Health Services Act (MHSA) Capacity Assessment Survey Report

Background

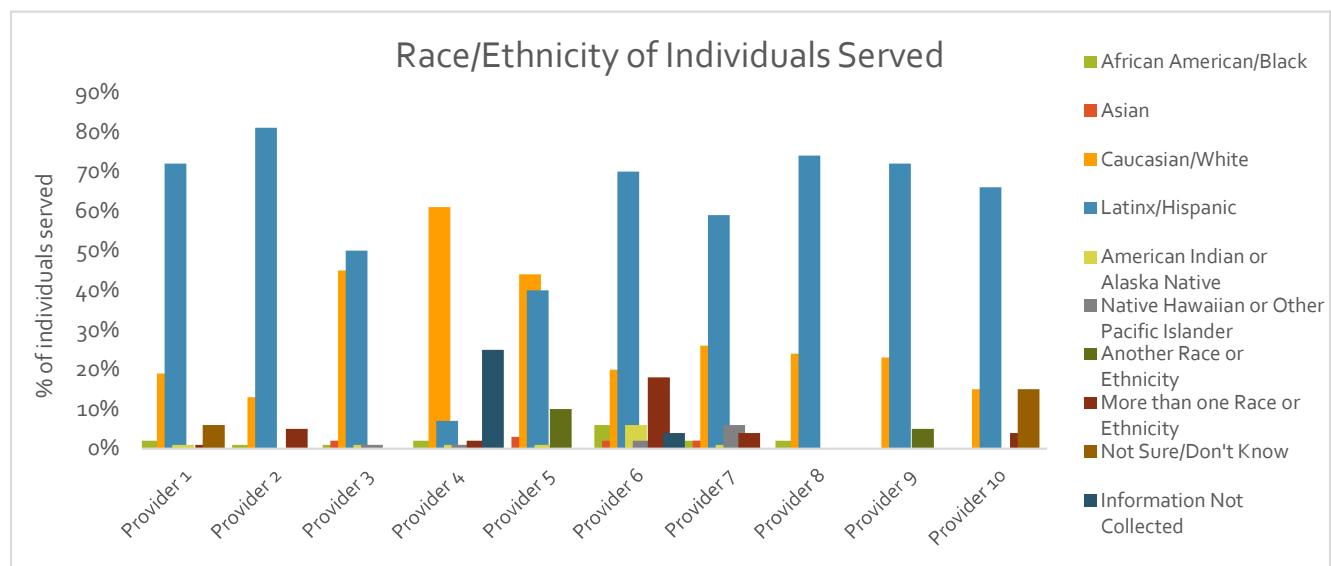
In the months of June through October 2023, Napa County MHSA administered a Capacity Assessment Survey across service providers. The survey included questions related to the recruitment and retention of Behavioral Health staff, hard to fill positions, the impact of vacancies on the provision of services, statistics of the different racial/ethnic, linguistic, gender identity, and sexual orientation groups represented among service providers as compared to the populations being served in Napa County. The survey also included questions about the possible barriers to implementing programs/services and the methods of addressing these barriers.

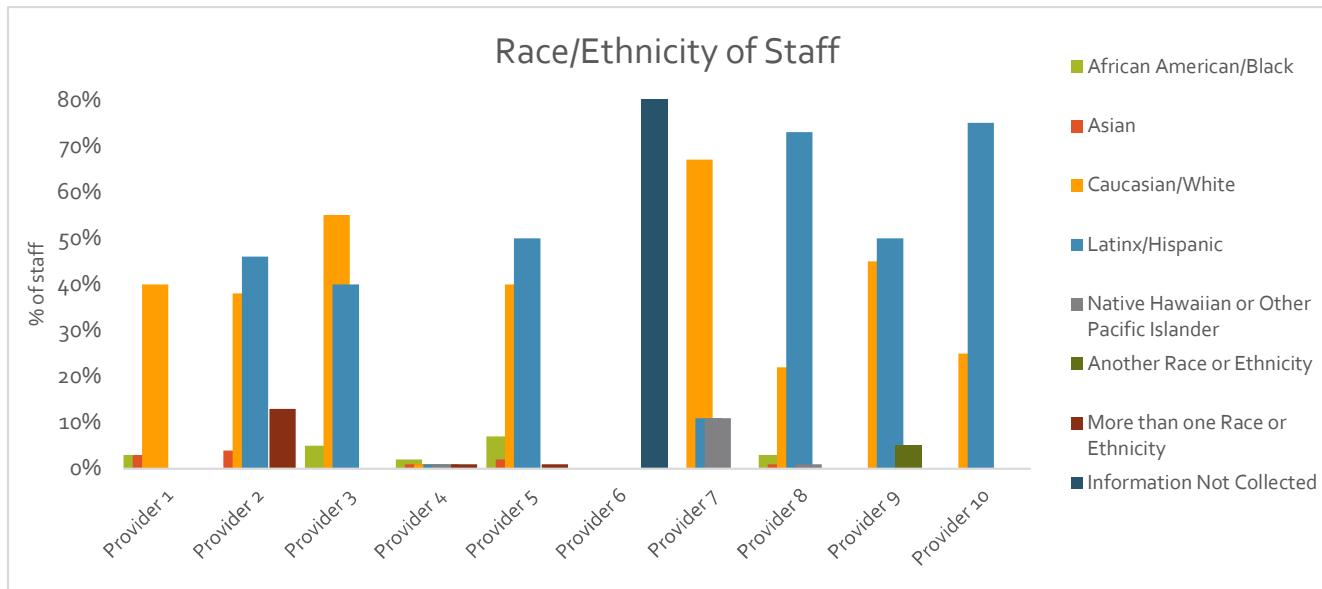
Results

A total of 12 surveys were received. Out of the surveys that were collected, 10 were completed and 2 were incomplete. The response to the question of the number of Behavioral Health staff currently in the provider organization ranged from 1 to 6 staff members or higher numbers of 30 to 128 staff members. Service providers indicated that the positions that are hard to fill include Licensed Mental Health Counselor, Bilingual Mental Health Therapist, Clinical Supervisor, LCSW Supervisor, and CLAR@ coordinator. 36% of the service providers indicated they have experienced difficulties in recruiting and retaining Behavioral Health staff positions, 45% felt they have not experienced difficulties, and 18% were not sure. Providers that responded to the percentage of Behavioral Health staff positions currently vacant within their organization ranged from 7% to 16%. 50% of the

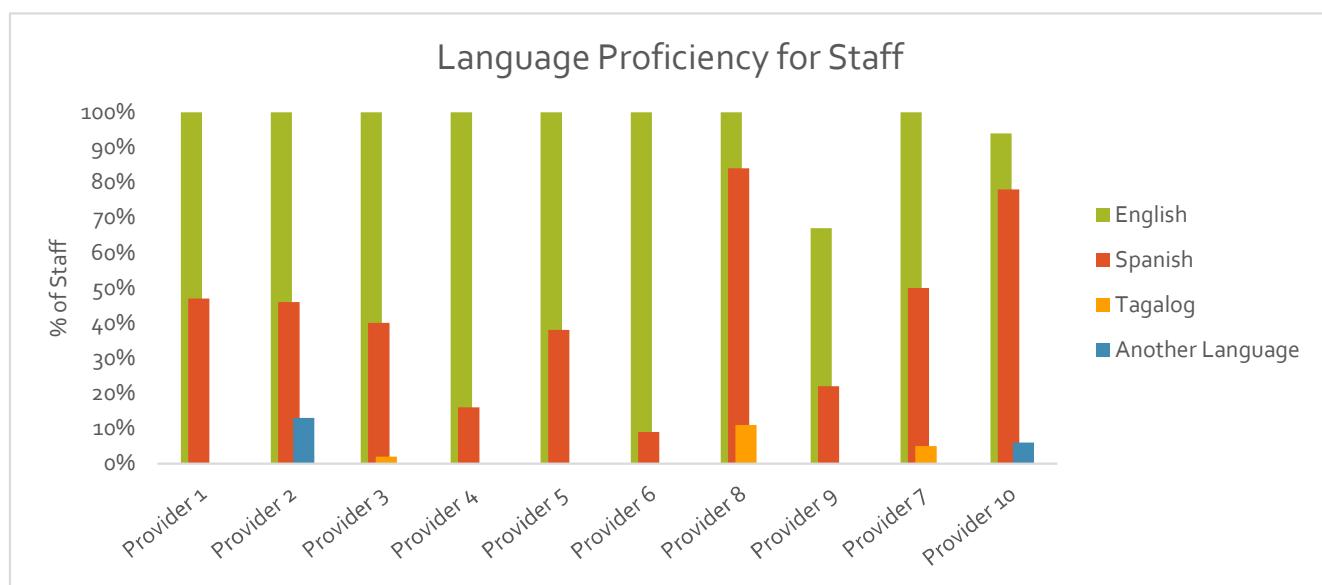
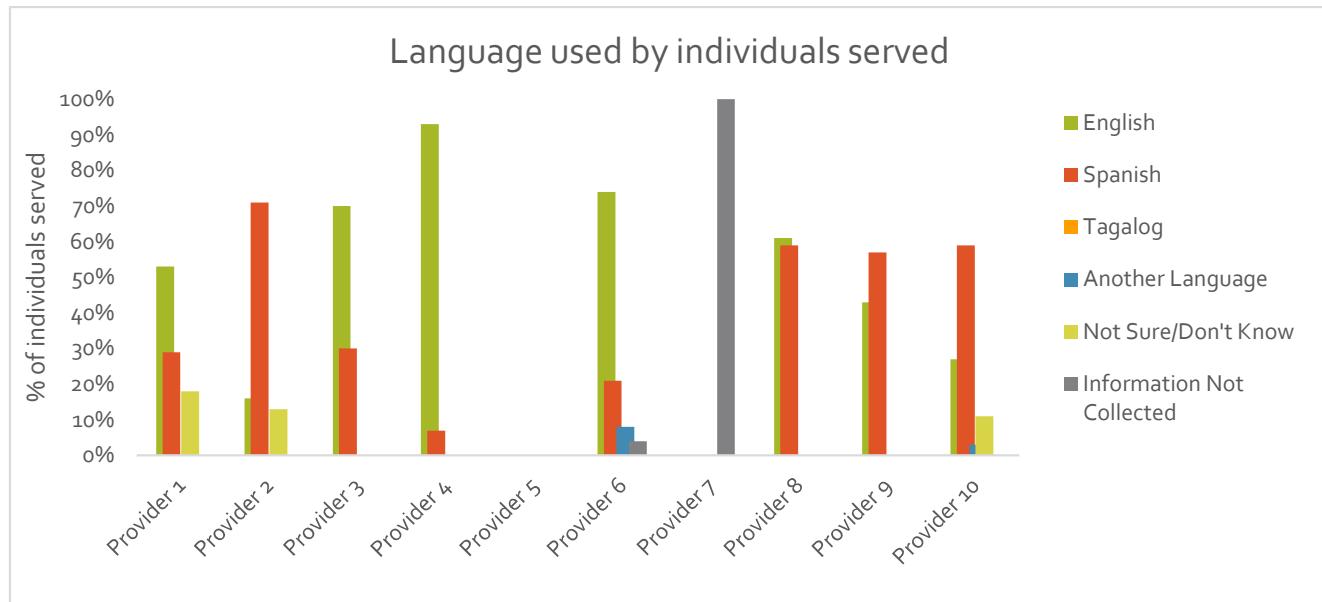
providers indicated that the vacancies in their organization were creating barriers to implementing services. Only 1 provider responded to the question of how staff vacancies have impacted their services by indicating that they have had to modify the number of mentoring groups because of staff vacancies.

The responses to the percentage of individuals served and their racial/ethnic identity showed that 50% to 81% of individuals served identify as Latinx/Hispanic. The second largest population served was Caucasian/White with a range of 44% to 61%. The percentage of other ethnicities such as African American/Black, Asian, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Another race/ethnicity, more than one race/ethnicity ranged from 1% to 18%. Some providers reported that they were not sure, or information was not collected for the individuals they serve. In comparison to the percentage of staff members and their racial/ethnic identity, 40% to 75% identified as Latinx/Hispanic, and 40% to 67% identified as Caucasian/White. The percentage of staff members that identified as African American/Black, Asian, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Another race/ethnicity, more than one race/ethnicity ranged from 1% to 13%. There was 1 provider that indicated racial/ethnicity information was not collected for their staff.





Providers were asked to provide a percentage breakdown of the different languages used by the individuals they serve and language proficiency for staff. Results showed that 53% to 93% of individuals served used English. Some providers indicated that 16% to 43% used English. The percentage of individuals served that used Spanish ranged from 57% to 71%. Some providers reported lower counts of 7% to 30% for Spanish. There were 2 providers that indicated 3% to 8% of the individuals they served used “another language,” and 11% to 18% of the language used by individuals served was unknown. Lastly, 1 provider indicated that language information was not collected at all. The results for the language proficiency of staff showed less variance in percentages for English as compared to that of individuals served. Providers indicated that 100% of their staff was proficient in English. Only 2 providers indicated a percentage less than 100. They reported 67% and 94% of their staff was proficient in English. The percentage of staff that was proficient in Spanish ranged from 50% to 84%, and others reported a lower range of 9% to 38%. Providers reported 2% to 55% were proficient in Tagalog. Providers also reported that 6% to 13% of their staff were proficient in another language.



In addition to the quantitative questions, providers were asked to share what is going well in their ability to meet the needs of diverse racial/ethnic and linguistic populations.

The responses were the following:

“47% of our staff are bilingual Spanish and we are able to provide our Spanish speaking consumers services in their preferred language the majority of the time without using an outside interpreter.”

“We have had success recruiting bilingual staff from the communities we serve, provide them with gold standard orientation and training and supporting their participation in certification or master’s programs.”

“Our team is committed to meeting our consumers’ needs and stepping in to support one another.”

"We have proportional amount of diverse, bicultural and bilingual staff to meet the needs."

"Our communication and outreach to the Hispanic communities has greatly increased after hiring a Spanish Program Coordinator. She is now able to be the point of contact for any of their needs, instead of having to work through a caseworker, family member, etc. which some Spanish-speaking seniors did not have."

"Connection with our Family Service team to our families. In our fall survey, 100% of families stated they knew who to contact at school, felt school staff as allies, and felt welcomed on campus."

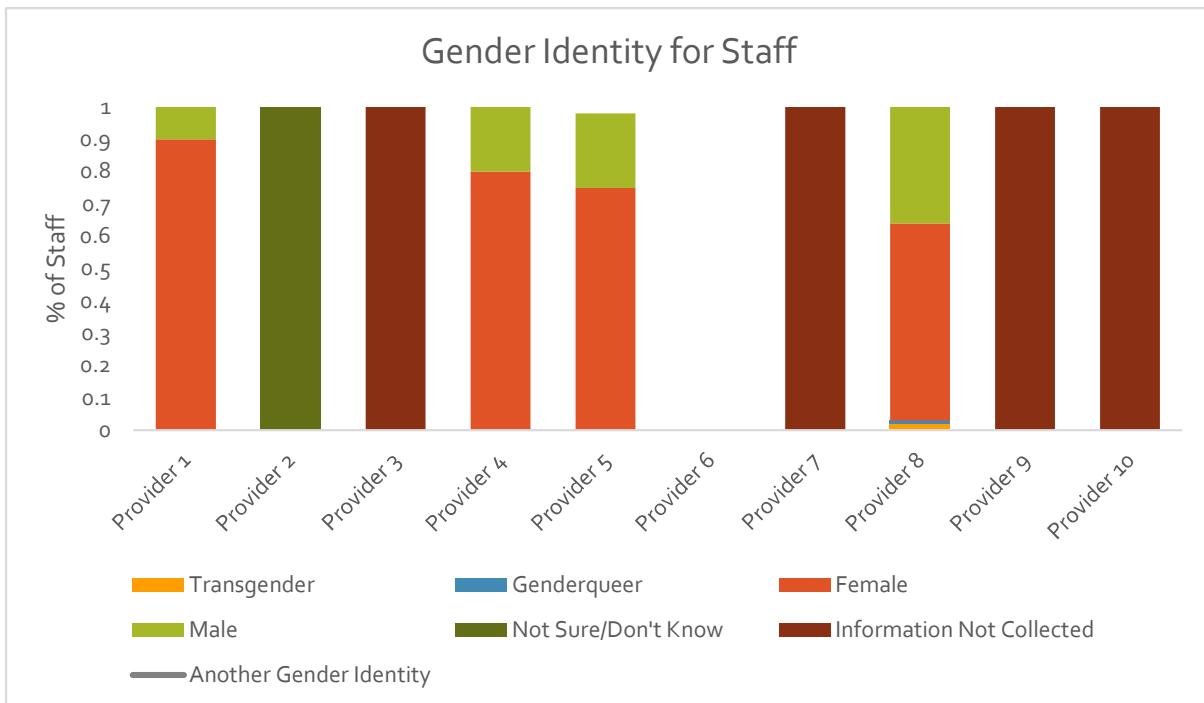
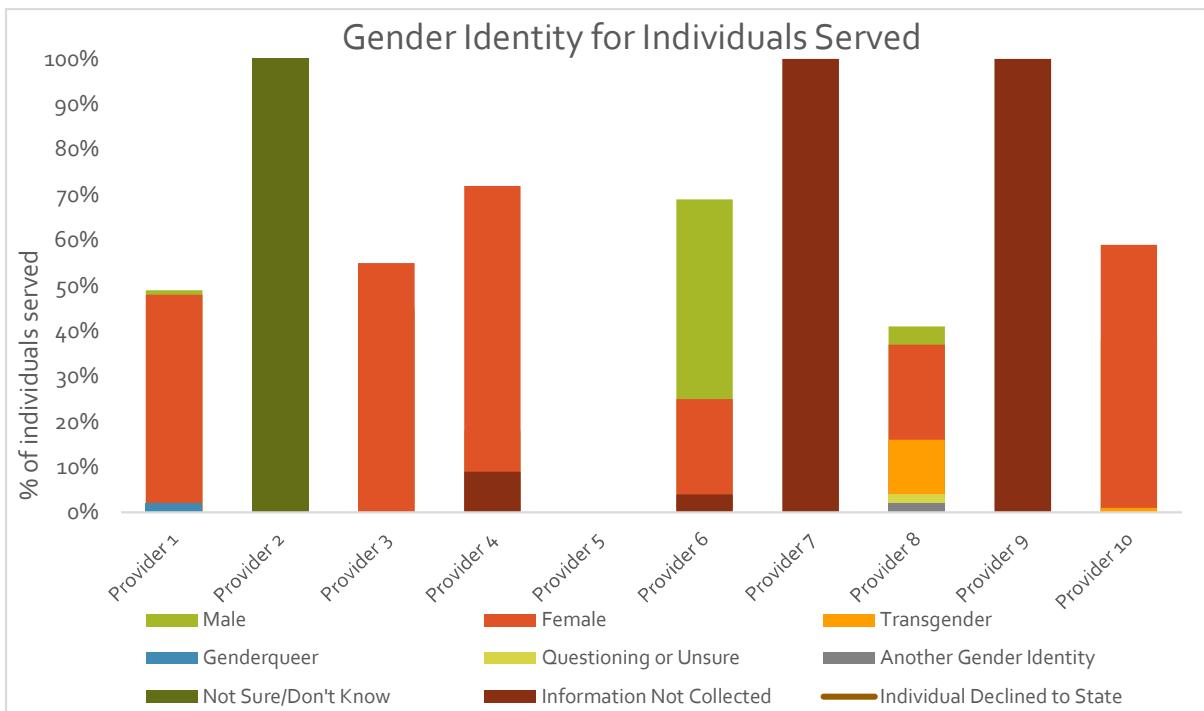
"DEI trainings, a focus on bringing in curriculum and support that is culturally competent, and a community willing to support continued learning and engagement. There continues to be less effort made in supporting the mental health needs of our Filipino community (translation, bicultural mental health staffing, outreach) than our Latino community."

"We are deeply connected to the community and has established leadership pipelines that feed our employment needs."

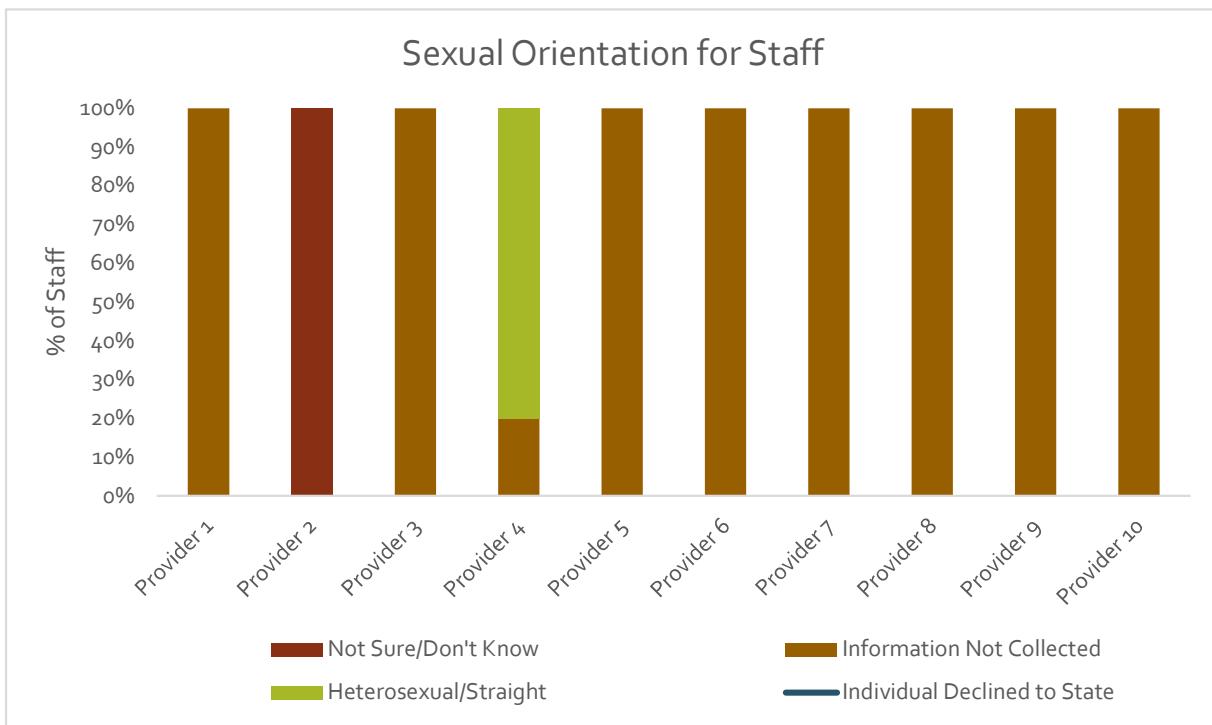
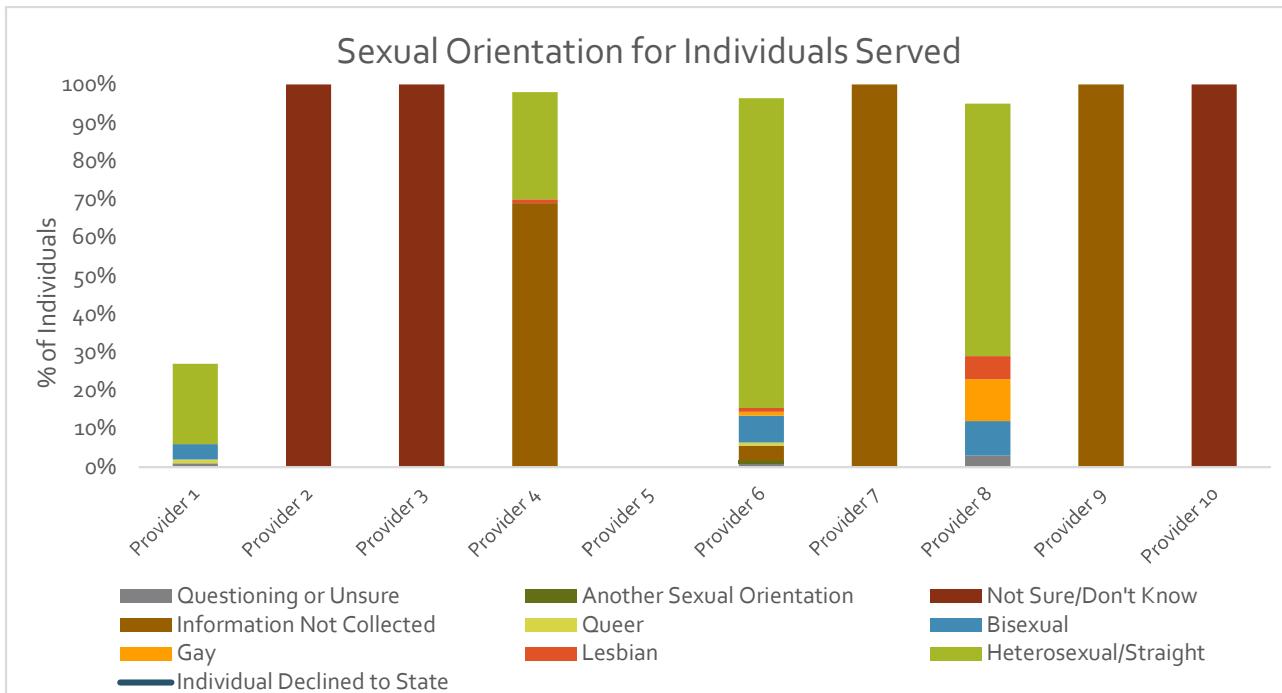
"The majority of our staff are bilingual (English/Spanish), highly experienced, have trusting relationships with consumers, and have strong working relationships with schools and CBOs."

The challenges providers face in their ability to meet the needs of diverse racial/ethnic and linguistic populations included limited candidate pools, low Medi-Cal rates that don't cover the cost of paying staff a competitive salary, lack of language ability beyond English and Spanish, and other racial/ethnic groups such as African American and Asian populations not being well represented in staffing.

The survey also addressed questions about the gender identity and sexual orientation of individuals served and staff members. Results showed that 18% to 49% of individuals served identify as male, and 25% to 72% identify as female. Some providers indicated that 1% to 16% identify as transgender, 2% identify as genderqueer and 1% to 2% declined to state. There were 3 providers that indicated gender identity information is not collected for individuals served. In comparison to staff members, results showed that 10% to 36% of staff identify as male, 61% to 90% identify as female, 2% identify as transgender, and 1% identify as genderqueer. There were 5 providers that indicated gender identity is not collected for staff members.



The results for sexual orientation were very limited. More than half of the providers that answered questions regarding the percentage of individuals served indicated that sexual orientation information is not collected, or information was unknown. In contrast to the information for staff, 9 out of 10 providers indicated that sexual orientation information is not collected, or information is unknown. Only 1 provider indicated that 80% of their staff identified as heterosexual and 20% information was not collected.



Providers were asked to share what they felt is going well in their ability to meet the needs of diverse gender identity/sexual orientation populations.

The responses were the following:

"We practice trauma informed and DEI principles and we are intentional about creating inclusive environments and fostering psychological safety at work, and creating safe spaces that are physically welcoming. We provide LGBTQ training

and ongoing cultural humility awareness for our staff."

"We feel we are working well with diverse gender identities and sexual orientations, and we do not have concerns in being able to effectively service these special populations."

"Educating students as a whole during the school year and celebrating Pride. We offer gender neutral bathrooms. We use student's preferred names and pronouns."

"As with DEI, our local resources, trainings, inclusion of accepting language in new curriculum and supports, all help our organization work closely with and in support of these communities."

"Our LGBTQ Connection is well known, and well respected, throughout the Bay Area. Many partners refer potential staff because of their relationship with LGBTQ Connection."

"Our agency serves all orientations it is not a factor in our service delivery. If this becomes relevant, we connect with community partners."

"Our entire staff received training from LGBTQ Connection this year."

The challenge providers shared they face in their ability to meet the needs of diverse gender identity/sexual orientation populations is their lack of collecting this information. Providers shared that there is a need to implement data tracking processes for gender and sexual orientation information for the individuals served as well as their staff members. Often people are not comfortable listing their gender/sexual orientation when filling out forms or employment applications. Providers acknowledge the importance of collecting gender identity/sexual orientation data so that they can align their policies and procedures to best serve all populations.

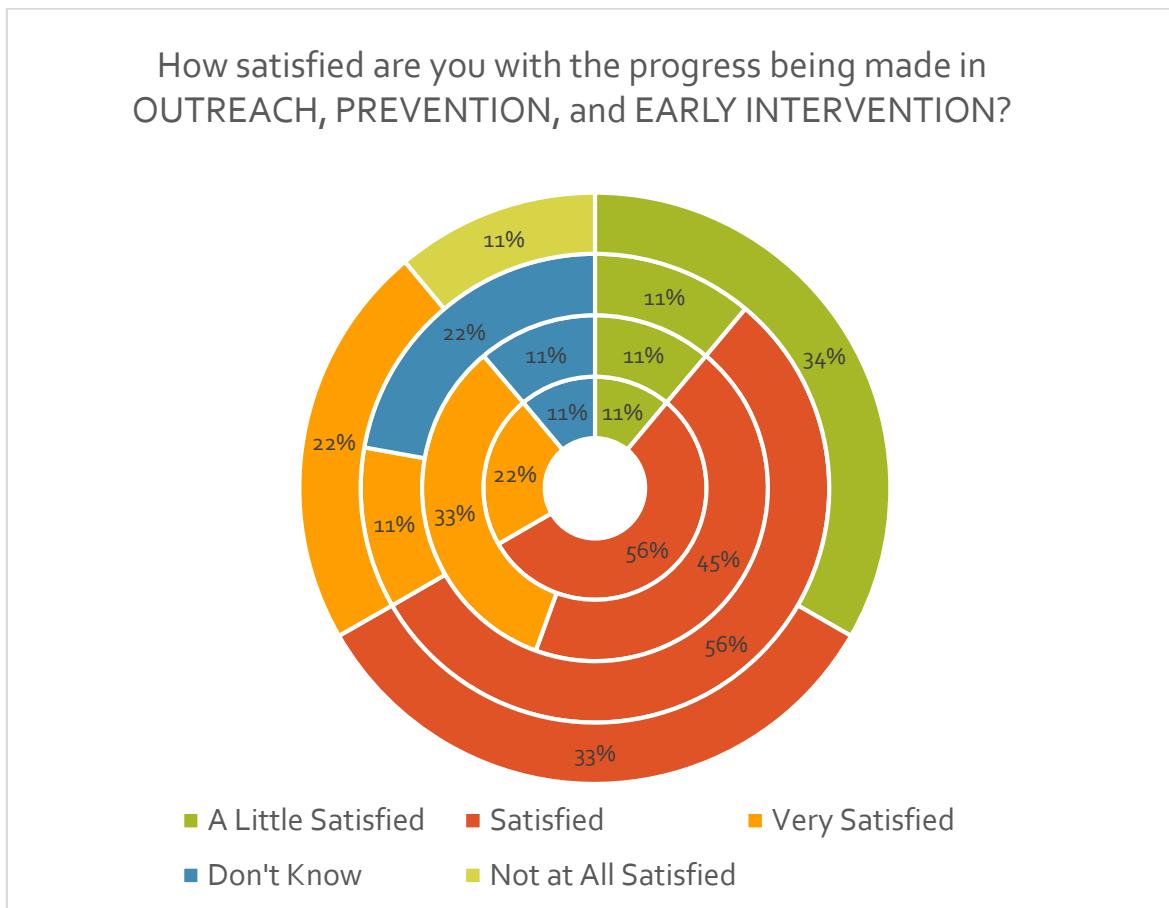
The survey gave providers an opportunity to share other barriers that they are currently experiencing to implementing Behavioral Health program/Services. The responses included challenges with funding, low rates, implementation of program/services is extremely costly, timely reimbursement, limited availability of providers, provider capacity, administrative burden, waitlists, and lack of solid referral network, consumer transportation, and data sharing.

Providers shared that they are addressing these barriers by partnering with Napa County leadership. They are seeking out a variety of funding opportunities such as grants, contracts, insurance billing and private fundraising. Providers indicated that they have identified community organizations specializing in behavioral health programs where they can refer consumers, they have expanded in-house programs that offer Mental Health services, additional direct service provider has been assigned to school campus, focusing work with schools, warm handoff referrals, building systems to streamline duties of existing staff to

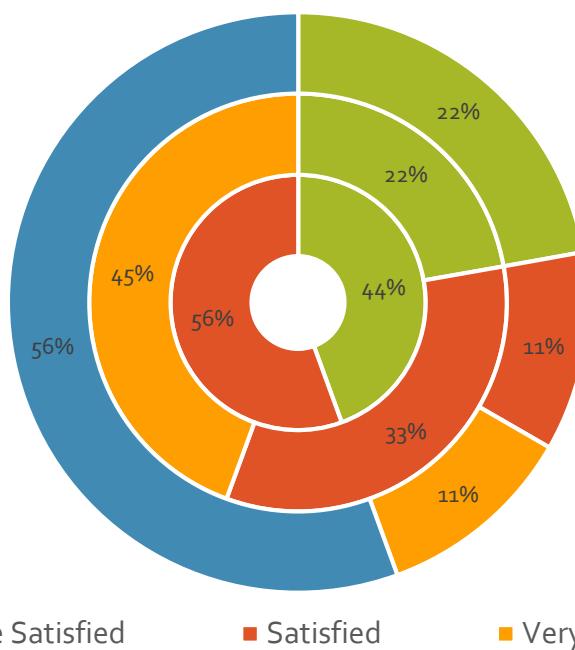
allow for more consumer support and services. Providers are collaborating and with one another to increase behavioral health services in schools. Providers indicate they are working hard to work through the barriers they are experiencing but emphasized that "grant administration is becoming harder and more cumbersome as County and State requirements increase, which takes time and resources away from service delivery."

Behavioral Health Priority Areas

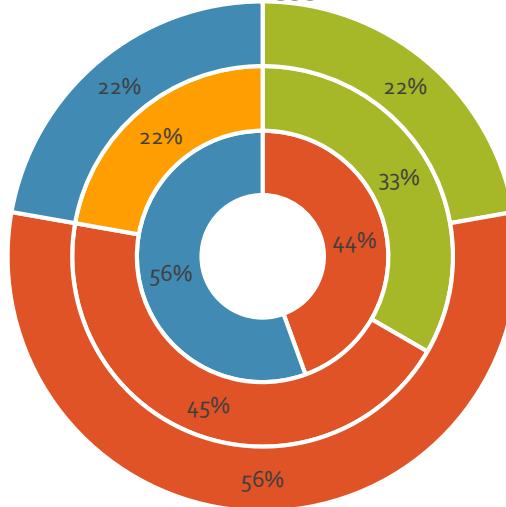
OUTREACH, PREVENTION and EARLY INTERVENTION: How satisfied are you with the progress being made in these areas?



How satisfied are you with the progress being made in
ACCESS, EQUITY, and LOCATION?



How satisfied are you with the progress being made in
SERVICES and SUPPORT for Individuals with Severe Mental
Illness?



■ A Little Satisfied ■ Satisfied ■ Very Satisfied ■ Don't Know ■ Not at All Satisfied

Appendix 2



Napa County HHSA-Mental Health Stakeholder Advisory Committee (SAC) Representative Roles and Responsibilities

Purpose: The document is intended to clarify the roles and responsibilities of Mental Health Stakeholder Advisory Committee (SAC) representatives.

Community Planning Process:

The Mental Health Services Act (MHSA) requires that county Mental Health departments submit Three Year Plans and Annual Updates to Three Year Plans detailing expenditures of MHSA funds and meaningful Community Planning Process (CPP) that involve local consumers and family members, providers, and other stakeholders as full partners from the inception of planning through implementation and evaluation of identified activities. The Napa County HHSA-Mental Health Division also seeks input from stakeholders on various issues and decisions related to mental health services in our community.

Mandated by California MHSA regulations, the CPP is a community collaboration process that is used to assess the current capacity of the MH Division to implement services, define underserved/unserved populations, and determine strategies to provide effective MHSA-funded programs that are: 1) Culturally Competent; 2) Client and Family-Driven; 3) Wellness, Recovery and Resilience-focused; and 4) Provide an Integrated Service Experience for Clients and their Families. (9 CCR § 3300).

The CPP must include a 30-day public comment period in which the Annual Update or Three Year Plan is posted and shared widely to solicit public input and feedback on the plan. At the close of the 30-day public comment period, a public hearing of the County Mental Health Board (MHB) is convened to: a) Review and approve the procedures used to ensure citizen and professional involvement in all stages of the planning process; and b) Review the adopted plan or update and make recommendations. Substantive comments are included in the Annual Update/Three Year Plan and may result in changes to the plan. The Annual Update/Three Year Plan is then submitted to the County Board of Supervisors for review and adoption before final submittal to the California Department of Health Care Services and the Mental Health Oversight and Accountability Commission.

Stakeholder Advisory Committee (SAC) Representation: Historically, SAC representatives have come from the following sectors, but are not limited to: consumers, family members, community-based organizations, mental health service providers, law enforcement partners, school personnel, community health providers, Mental Health Board members, and Substance Use Disorder service providers. Representatives from unserved and underserved populations are also recruited for this committee and include priority populations such as: Asian/Pacific Islander (API), LGBTQ, Older adults, Veterans, Latinos, Faith-Based Community, Up Valley/American Canyon – geographically underserved representation.



Napa County HHSA-Mental Health Stakeholder Advisory Committee (SAC) Representative Roles and Responsibilities

Each constituency group will select a representative(s) to participate on the Stakeholder Advisory Committee. Representative must be a Napa County resident or work in an agency which provides behavioral health services in Napa County. If the representative's residency or workplace changes and the representative no longer lives in Napa County or no longer works for a constituency program in Napa County, the constituency group for which they are representing will need to select a new representative.

Stakeholder Advisory Committee Representative Responsibilities:

- Share information with their constituency group to ensure comprehensive and ongoing participation from a diverse group of persons meeting the criteria for their constituency group. There must be a concerted effort to include individuals who may not be part of routine advocacy groups and/or who may have been previously underserved.
- Represent the views of their constituency group as a whole rather than their individual or agency agenda(s). The SAC is not a place to advocate for funding for an individual entity or organization, nor does it mean that attendance will guarantee funding. The SAC is intended to be a safe place for members to voice their concerns and share input in order to increase access and reduce barriers to services for their unserved/underserved constituents.
- Request trainings or presentations from MHSA staff to help the constituency members understand the requirements and the stakeholder planning process. At the request of the constituency group, the county can provide information on the planning process and/or assist in providing trainings. Share the documentation of constituency meetings/information-sharing with the Mental Health Division Project Manager which may include:
- Review SAC Agenda materials sent for review prior to the next SAC meeting to ensure efficient and productive SAC Meetings
- Attend monthly Mental Health Stakeholder Advisory Committee Meetings during which the representative is encouraged to:
 - Provide verbal or written report on relevant activities of their constituency.
 - Provide input and support to develop the SAC monthly agenda to further the SAC's goals and interests.
 - Provide input on the MHSA Three Year Plan and Annual Updates to Three Plan and other Mental Health strategic planning/funding recommendations
 - Participate actively in discussions and input on agenda items
 - Be prepared to vote, take action, and decide on next steps on agenda items
 - Attend special meetings as needed
- Share information with other SAC members, individuals, providers, etc. and disseminate minutes, information, feedback, and outcome of action items from SAC meetings to their individual constituencies.



**Napa County HHSA-Mental Health
Stakeholder Advisory Committee (SAC)
Representative Roles and Responsibilities**

- Make known in writing any financial or additional supports requested such as stipends, childcare, supplemental meals, housing, and transportation assistance as necessary to ensure constituency involvement. The MH Division Project Manager must approve such expenditures in advance of the expenditure



The PEI Project: Achieving More Together to Support Californians

Fiscal Year 2023-24 Impact

Participating California counties pool local Prevention and Early Intervention (PEI) funds through the California Mental Health Services Authority (CalMHSA) to support the ongoing implementation of the PEI Project statewide. The PEI Project consists of a series of campaigns designed to raise awareness about mental health needs, reduce stigma, prevent suicides and promote mental wellness.

In 2021, CalMHSA, following direction from its Board of Directors, began reimagining the next phase of its PEI Project, which led to the creation of *Take Action for Mental Health*. This multi-faceted statewide public awareness initiative encourages individuals to take proactive steps for their own mental health and the mental health of others through three key pillars: **Check In**, which promotes staying connected and engaged in conversations about well-being; **Learn More**, which emphasizes the importance of mental health education to reduce stigma and increase understanding; and **Get Support**, which encourages individuals to seek professional help or access community resources to address mental health challenges.

The PEI Project's impact extends beyond county lines, spreading the message of *Take Action for Mental Health* throughout California. This statewide effort is essential for fostering a culture of mental wellness, regardless of where people live, work or play. In FY 2023-24, the project focused on diversity, equity and inclusion, with a particular emphasis on supporting marginalized communities. Key initiatives included:

- **Juneteenth** micro-campaign
- Collaborations with streetwear designer and influencer **Khano Ngo** for the AAPI community
- Support for **Transgender Day of Remembrance** and **Pride Month**

Statewide Achievements in FY 2023-24

The *Take Action 4 Mental Health* campaign disseminated both physical and digital materials for key events, including:

- **Mental Health Awareness Month** (May)
- **Juneteenth**

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- **Pride Month (July)**
- **Suicide Prevention Week and Month (September)**
- **Winter Wellness (December-January)**

Outreach to Youth and Young Adults

The PEI Project continues to prioritize outreach to younger populations, with approximately **61.67% of support provided to individuals under 25 years old** (as defined by Title 9 Regulations). Below are the estimates for outreach and program evaluation within this demographic:

- **Outreach:** 55% of participants are under 25 years old (social media); 55% toolkits and collateral
- **Evaluation:** 65% of individuals served are under 25

Paid Media Impact

The PEI Project achieved significant reach through paid media efforts, with the following key metrics:

- **Total:** 9,134,360
 - General Market: 5,360,571
 - Hispanic Market: 1,081,843
 - LGBTQIA+ and BIPOC Communities: 2,691,946
- **Total Reach:** 1,694,234
 - General Market: 1,112,970
 - Hispanic Market: 338,420
 - LGBTQIA+ and BIPOC Communities: 603,552

Organic Social Media Impact

The PEI Project saw notable impact through organic social media with the following key metrics:

- **Total Reach:** 16,119
- **Total Engagement:** 484 (likes, reposts, views, mentions)

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Take Action Website Metrics

The *Take Action for Mental Health* website has become a key resource for individuals seeking mental health information and tools:

- **Sessions:** 105,558
- **Resources Downloaded:** 9,133

September 2023 – Suicide Prevention Week: Suicide Prevention Activation Kit

The **Suicide Prevention Activation Kit** provides a range of resources to support individuals and organizations in raising awareness during **National Suicide Prevention Awareness Week** and throughout the year. Key materials in the kit include:

- Guides for creating **social media posts**
- **Infographics** for awareness campaigns
- **Activity Tip Sheets** for community engagement
- **Downloadable posters** tailored for diverse communities

These resources aim to help individuals recognize warning signs, initiate meaningful conversations, and connect with local suicide prevention resources. The goal of the kit is to empower everyone to take action and promote the importance of suicide prevention.

Website Activity During Suicide Prevention Week:

- **Sessions:** 5,246
- **Resources Downloaded:** 1,124

These metrics highlight the active engagement and utilization of the resources during **Suicide Prevention Awareness Week**.

December 2023 – Winter Wellness

The **Winter Wellness Digital Toolkit** offers resources designed to help individuals maintain their mental well-being during the colder months. This toolkit addresses the unique challenges of winter, including **seasonal affective disorder (SAD)** and isolation. It includes practical materials such as:

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- **Wellness tips** for managing winter-related stress
- **Activity guides** to promote engagement and connection
- **Social media content** to raise awareness and encourage self-care

These resources support individuals in prioritizing self-care, staying connected, and engaging in positive activities that promote mental health during the winter season.

Resource Link: [Winter Wellness Archives - Take Action for Mental Health](#)

May 2024 – May is Mental Health Matters Month

The **May is Mental Health Matters Month 2024 Toolkit** includes essential resources to raise awareness and promote mental health during **Mental Health Matters Month** in May. The toolkit contains:

- **Social media content**
- **Educational resources**
- **Activity ideas**

These resources are designed to reduce stigma, increase understanding, and encourage open conversations about mental health. They equip individuals and organizations with the tools to engage communities, raise awareness, and create a supportive environment for mental well-being, with a focus on inspiring action year-round.

Website Campaign Results:

- **Sessions:** 67,218 (14.5x increase month-over-month compared to April 2024)
- **Resources Downloaded:** 1,930 (Nearly 2x increase month-over-month compared to April 2024)

A specialized landing page for this campaign generated **48,216 sessions**, and the paid media campaign drove **86%** of the total website traffic in May.

Link to Resources: [May is Mental Health Matters Month Archives - Take Action for Mental Health](#)

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June 2024 – Pride Month

The **Pride Digital Toolkit** provides resources to support mental health and well-being within the **LGBTQIA+** community during Pride Month and beyond. The toolkit includes:

- **Social media content**
- **Educational materials**
- **Activity ideas**

These resources promote inclusivity, reduce stigma, and celebrate LGBTQIA+ identities. The goal is to create supportive environments, raise awareness about mental health challenges, and crucial resources.

Link to Resources: [PRIDE Month Archives - Take Action for Mental Health](#)

June 2024 – Juneteenth

The **Juneteenth Digital Toolkit** promotes mental wellness and raises awareness about the significance of **Juneteenth**, which celebrates the emancipation of enslaved African Americans. The toolkit includes:

- **Social media content**
- **Activity ideas**
- **Educational resources**

These materials encourage conversations, foster unity, and support mental health in Black communities, emphasizing both historical reflection and contemporary issues.

Link to Resources: [Juneteenth Archives - Take Action for Mental Health](#)

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Appendix 4

Public Comments and Responses

The Draft FY 2025–26 MHSA Annual Update was posted for a 30-day public review and comment period from November 3, 2025, to December 3, 2025.

Comment	Response/Action Taken
<p>Date Received: December 1, 2025 Name/Organization: Molly's Angels of Napa Valley Topic/Area: Older Adult Services, Transportation, PEI Transition Summary of Public Comment: Comment expressed strong support for County priorities related to equity, access, and early intervention, and affirmed older adults as a priority population. Key themes included social isolation, transportation barriers, service navigation challenges, and the need for bilingual and culturally responsive outreach. The commenter emphasized the role of transportation and community-based outreach in preventing missed appointments, reducing crisis risk, and improving continuity of care for seniors. The comment also encouraged sustaining older-adult prevention and early-intervention supports during the transition from MHSA to BHSA.</p>	<p>Napa County Behavioral Health thanked the organization for its input and affirmed its continued commitment to older adults as a priority population. The County acknowledged the importance of transportation and outreach in supporting continuity of care and reducing crisis risk. The County also reiterated its intent to prioritize early-intervention and community-based supports for older adults as planning continues for the BHSA transition.</p>

Modifications to the FY 2025–26 MHSA Annual Update

Section Revised	Change Made
The comment aligned with existing priorities, and no substantive changes were required to the Annual Update.	N/A

Public Comment Submitted December 1, 2025

Submitted by: Molly's Angels of Napa Valley

Molly's Angels of Napa Valley
433 Soscol Ave., Suite A-100
Napa, CA 94559

December 1, 2025

Formal Public Comment

Re: Napa County MHSA FY 2025–2026 Annual Update to the Three-Year Plan

Thank you for the opportunity to provide public comment on Napa County's MHSA FY 2025–2026 Annual Update. Molly's Angels appreciates the County's continued commitment to equity, access, and community collaboration in behavioral health. We also want to acknowledge the thoughtful inclusion of older-adult needs throughout the Update, as well as the recognition of our Older Adult PEI Program during the Community Planning Process.

Support for the County's Priorities

The Annual Update accurately reflects challenges we see daily among older adults, including social isolation, transportation barriers, difficulty navigating services, and the need for bilingual and culturally responsive outreach. We strongly support the County's emphasis on improving access, strengthening system navigation, and reducing disparities for underserved residents.

Older Adults as a Priority Population

As highlighted in the Update, Napa County has a large and growing older-adult population with elevated risks for isolation, depression, and unmet behavioral health needs. Molly's Angels serves these individuals by providing connection, reassurance, and hands-on support navigating resources—often serving as the first point of contact before a behavioral health condition escalates.

Transportation as a Behavioral Health Access Issue

Transportation barriers are repeatedly identified throughout the MHSA Update, and Molly's Angels plays a significant role in addressing them. We currently provide rides for older adults to therapy appointments, psychiatric care, counseling, wellness checks, and other behavioral-health-related visits.

While we do not provide rides specifically for substance-use treatment—a major focus of MHSA and forthcoming BHSA funding—we help fill a critical gap for seniors who require consistent access to mental health services but face mobility or isolation-related barriers. These rides often prevent missed appointments, reduce crisis risk, and improve continuity of care.

Outreach, Education & Community Partnerships

We appreciate the Update's emphasis on outreach and early engagement, and we want to underscore Molly's Angels' growing role in this area.

MHSA-supported efforts have allowed us to expand outreach through:

- Mental health flyers and informational materials distributed to hundreds of seniors and caregivers.
- Resource fairs, including our annual Holiday Luncheon, where County and CBO partners present behavioral-health information directly to older adults.
- Cross-sector collaborative events that connect seniors to County services, crisis support, peer programs, and early-intervention pathways.
- Raising awareness through our bi-monthly radio program, "Senior Moments," which periodically features behavioral-health organizations and helps seniors learn about available supports in an accessible, familiar format.

These efforts help normalize mental-health conversations, reduce stigma, and ensure seniors—especially monolingual, isolated, or rural residents—are aware of available supports long before a crisis occurs.

PEI Transition and Program Sustainability

As the County prepares for the transition to the Behavioral Health Services Act and the sunset of dedicated PEI funding, we urge continued attention to sustaining outreach and early-intervention supports for older adults. Seniors benefit significantly from early-touchpoint programs such as transportation, reassurance calls, and resource navigation—services that keep individuals connected, stable, and less likely to require higher-level care.

Ongoing Partnership and Collaboration

We value the County's transparent and inclusive Community Planning Process and appreciate the opportunity to participate through the Stakeholder Advisory Committee. Molly's Angels remains committed to partnering with HHSA to strengthen behavioral health outcomes, reduce inequities, and ensure older adults across Napa County can access the care, connection, and resources they need.

Thank you for your leadership and for the opportunity to comment. We look forward to supporting the County as it prepares the BHSA Integrated Plan and advances a coordinated, equitable behavioral health system.

Respectfully submitted,

Devereaux Smith, MPA

Executive Director

Molly's Angels of Napa Valley

County Response

Napa County Behavioral Health thanks Molly's Angels of Napa Valley for its thoughtful public comment and continued partnership in serving older adults across the community. The County appreciates the organization's support of MHSA priorities related to equity, access, outreach, and early intervention, as well as its recognition of the importance of addressing isolation, transportation, and service-navigation barriers for seniors.

The Annual Update's focus on older adults as a priority population reflects the County's ongoing commitment to improving access to behavioral health services for aging residents, particularly those who are isolated, monolingual, rural, or mobility limited. The County acknowledges the critical role that transportation and outreach services play in preventing missed appointments, reducing crisis risk, and strengthening continuity of care.

As Napa County transitions from MHSA to the Behavioral Health Services Act, the County will continue to prioritize early-intervention, and community-based supports that promote stability and wellness for older adults. The County values continued collaboration with Molly's Angels and other community partners as it advances an integrated, equitable behavioral health system.