

# Bridge to Recovery

CO01 – North Central Region, District 1  
University of California, San Diego



In Fiscal Year (FY) 2012-13, the University of California, San Diego (UCSD) Bridge to Recovery Program provided screening, brief intervention, and referral to treatment (SBIRT) services to 1,375 unduplicated, new clients in the San Diego County Psychiatric Hospital’s (SDCPH) Crisis Recovery Unit (CRU) and Emergency Psychiatric Unit (EPU), Gary and Mary West Senior Wellness Center, Gifford Walk-In Clinic, Jane Westin Walk-In Clinic, Bridge to Recovery Walk-In, and Bridge to Recovery Case Management Program. All participants had co-occurring disorders.

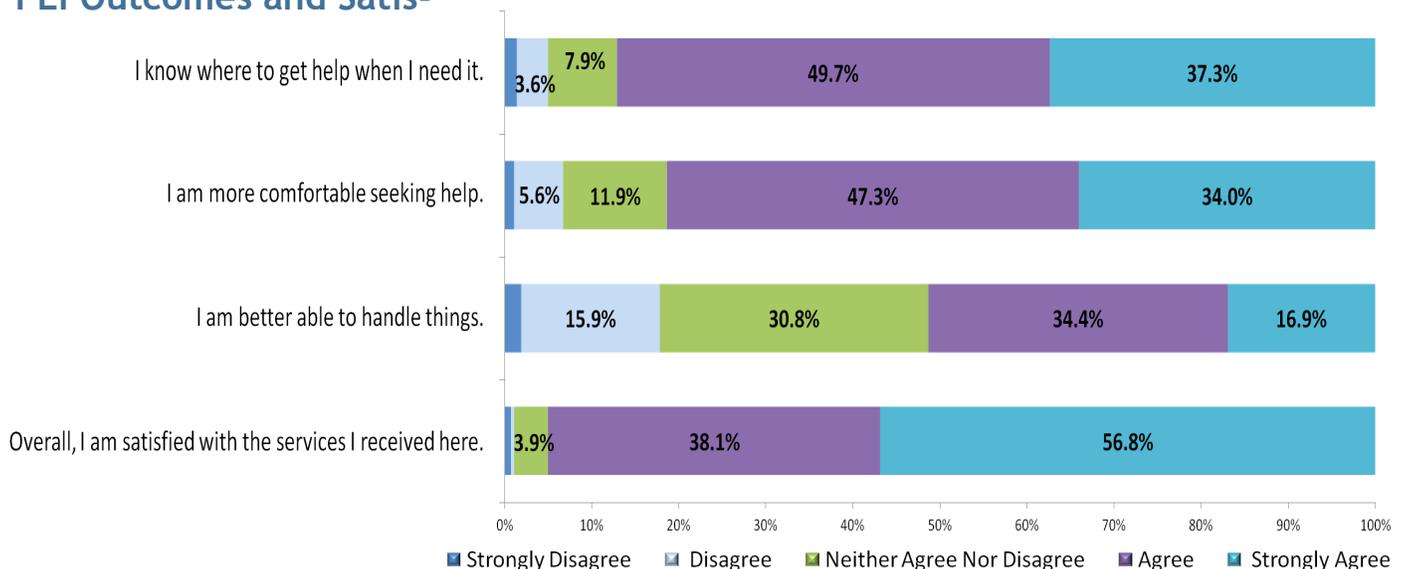
The goal of the UCSD Bridge to Recovery program, part of the Prevention and Early Intervention (PEI) plan, is to provide screening, brief intervention, education, linkages, outreach, and referrals to individuals with co-occurring disorders who access one of the locations mentioned above. Then, the program offers follow-up short-term case management support to link appropriate participants to needed treatment or other resources to

create stability, instill hope, reduce stigma about seeking treatment, and reduce suicidal risk factors.

Using a short-term case management model, brief intervention is delivered to educate and engage at-risk individuals with substance abuse issues, who would benefit from interventions by peer specialists and/or clinicians. The Bridge to Recovery program also provides referral to specialty care services for those identified as needing more extensive treatment.

The UCSD Bridge to Recovery Program is one of many programs implemented as a result of the Mental Health Services Act (MHSA). Originally passed by voters as Proposition 63, the MHSA became state law effective January 1, 2005. MHSA funding gives counties a unique opportunity to implement programs to prevent the onset of mental illness or to provide early intervention to help decrease severity.

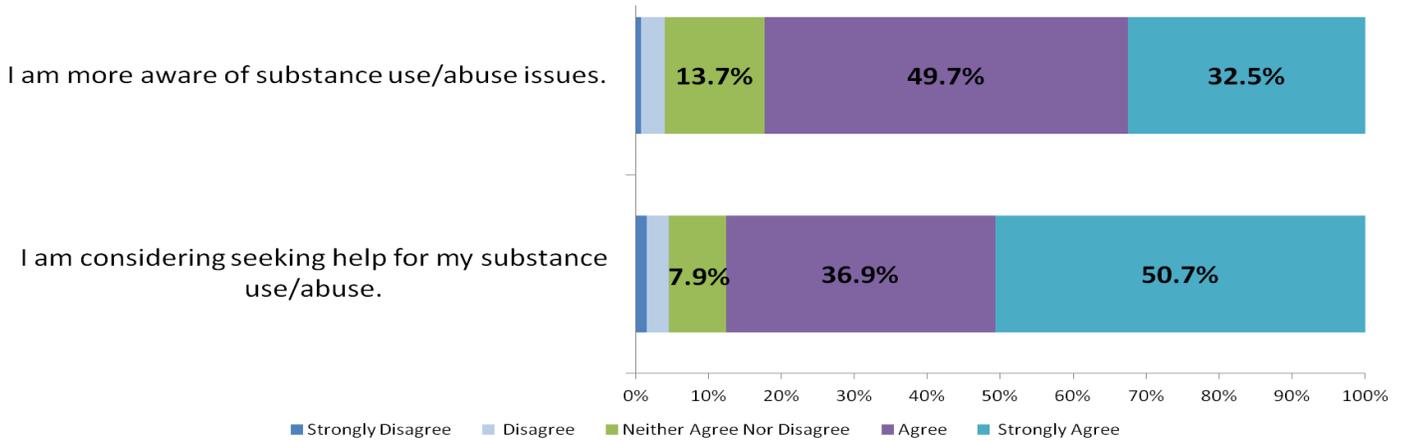
## PEI Outcomes and Satis-



Participants were asked to assess both their improvement and their satisfaction with several areas of the Bridge to Recovery Program after completion of the first session of the intervention. The majority of participants either “Agreed” or “Strongly Agreed” that, because of the intervention, “I know where to get help when I need it” (87.0%) and “I am more comfortable seeking help” (81.3%). Half of respondents “Agreed” or “Strongly Agreed” that, “I am better able to handle things” (51.3%). It is likely that fewer participants agreed with this question because of the timing of the survey—only a moderate response on overall improvement in coping can be expected after one contact with a participant. Most participants “Agreed” or “Strongly Agreed” that, “Overall, I am satisfied with the services I received here” (94.9%).

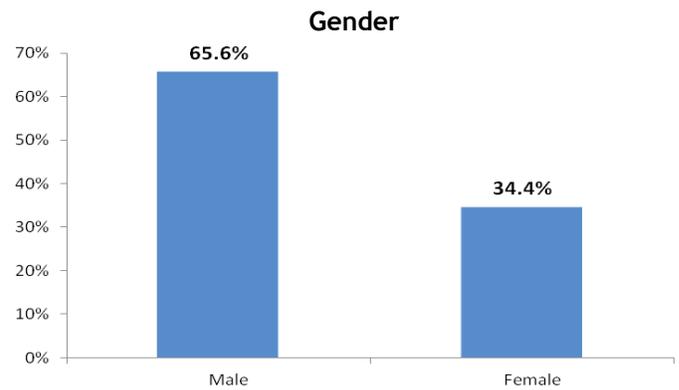
## Program Specific Outcomes

Bridge to Recovery participants also assessed benefits they received from the program related to their substance use. A majority of the participants either “Agreed” or “Strongly Agreed” that, because of the program, “I am more aware of substance use/abuse issues” (82.2%) and, “I am considering seeking help for my substance use/abuse” (87.6%).

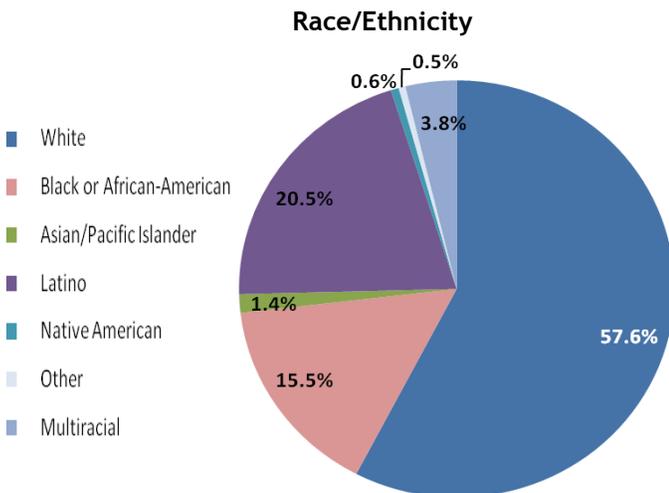


## Participant Demographics

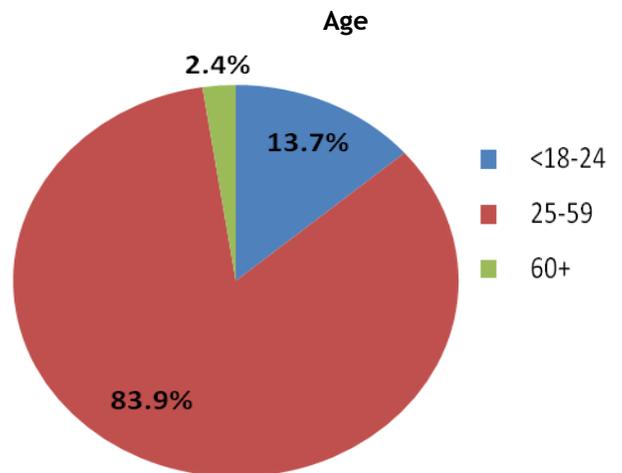
During FY 2012-13, Bridge to Recovery provided services to 1,375 new participants. The majority of participants were male (65.6%), White (57.6%), and 25-59 years old (83.9%). Participants’ average age was 38.1 years. A small percentage of participants had served in the military (6.5%), with most serving in the Navy (27.2%), Army (23.9%), or Marine Corps (19.6%).



Note. Other gender was reported by 2 participants and were not included



Note. 190 participants did not provide race/ethnicity and were excluded



HEALTH SERVICES RESEARCH CENTER is a non-profit research organization within the University of California, San Diego Department of Family and Preventive Medicine. HSRC works in collaboration with the Performance Outcomes and Quality Improvement Unit of San Diego County Behavioral Health Services to evaluate and improve mental health outcomes for County residents. Our research team specializes in the measurement, collection and analysis of health outcomes data to help improve health care delivery systems and, ultimately, to improve participant quality of life. For more information about HSRC please contact Andrew Sarkin, PhD at 858-622-1771.



## Community Based Alcohol and Drug Services Program

CO02 – Central, East, South, N. Coastal,  
N. Inland, N. Central Regions  
Districts 1, 2, 4, 5



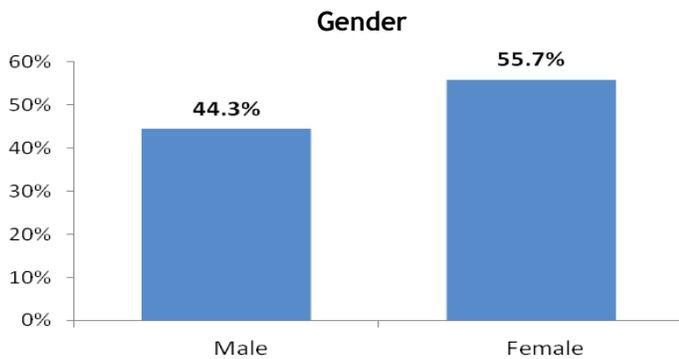
This Prevention and Early Intervention (PEI) project has added mental health counselors to 28 Alcohol and Drug Services (ADS) treatment programs to identify and screen for clients who exhibit mental health concerns. Interventions applied are best practices that are age appropriate, integrated, accessible, culturally competent, and strength based.

The Community Based Alcohol and Drug Services Program ensures that clients with substance abuse issues who are experiencing co-occurring mental health problems receive services that comprehensively address both issues. This approach supports clients in their efforts to attain and maintain an alcohol and drug free style of living. Mental health counselors in the programs conduct mental health screenings at on-site ADS treatment sites, including developmentally appropriate screenings for children and older adults.

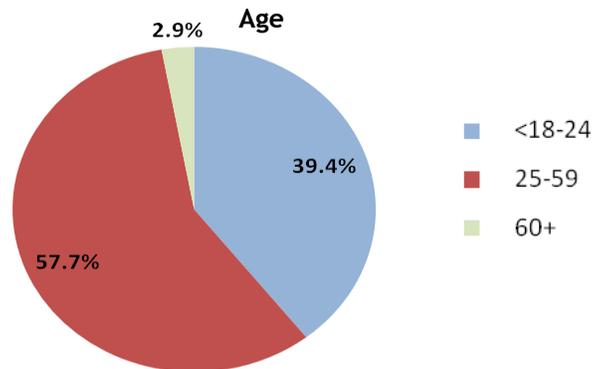
Counselors perform assessments, provide mental health education and brief counseling to reduce risk factors or stressors, facilitate linkages to additional mental health services, and assist clients in developing life skills to help them maintain longer periods of sobriety. They also provide support to ADS staff through consultation in team meetings. Counselors also provide services that support the treatment and recovery of clients' family members, offering: prevention groups for children of parents in recovery that build protective factors and communication skills; family assessment and linkage to behavioral health and other services to decrease stress; and information and education for parents about early signs of problems with their children and ways to manage them.

### Participant Demographics

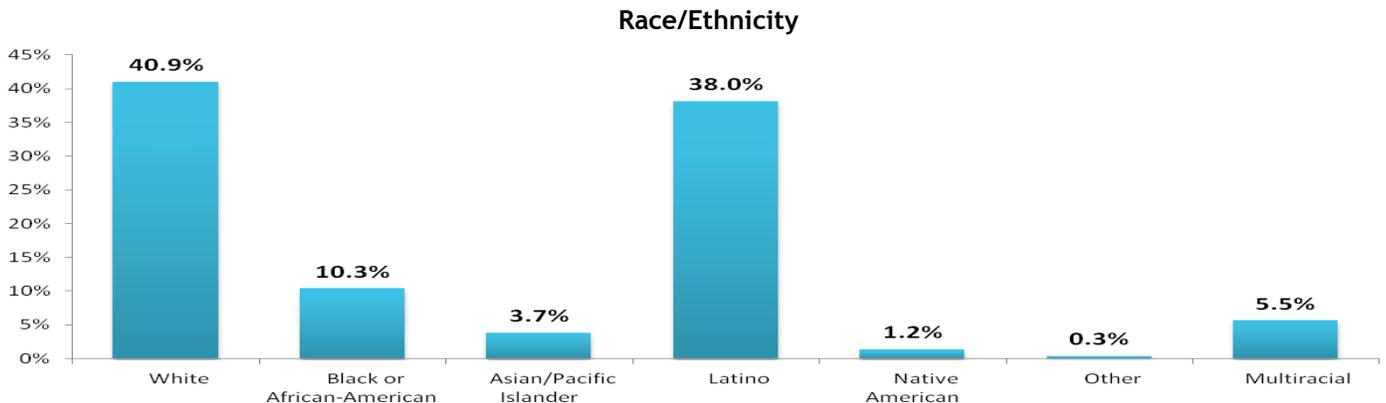
Demographics were collected for 879 PEI participants. Participants reflect the diverse population found in San Diego County. About 4% of the participants served in the military.



Note. 1 participant reported 'other', and 56 did not report gender and were excluded



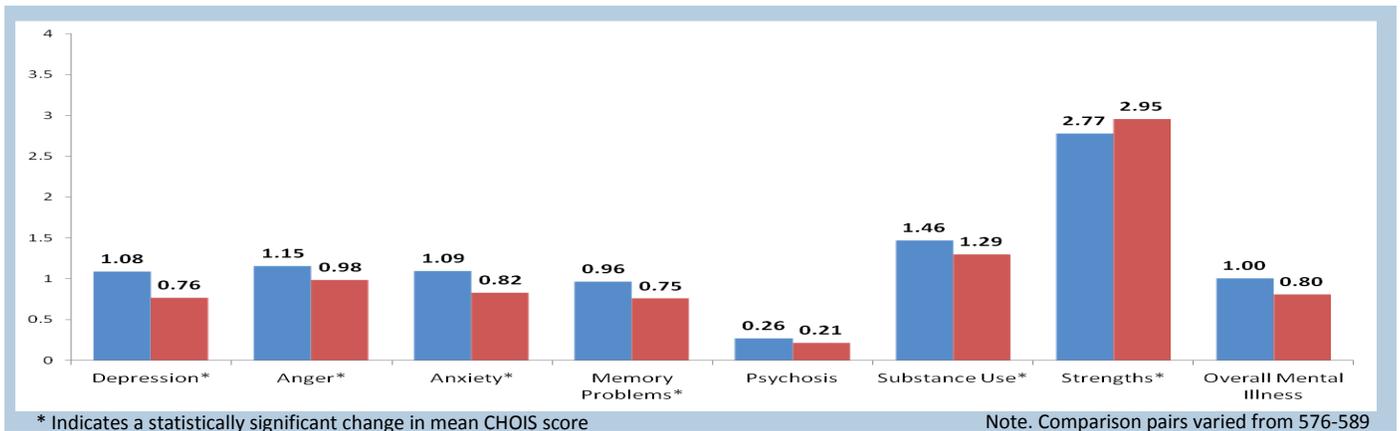
Note. 143 participants did not report age and were excluded



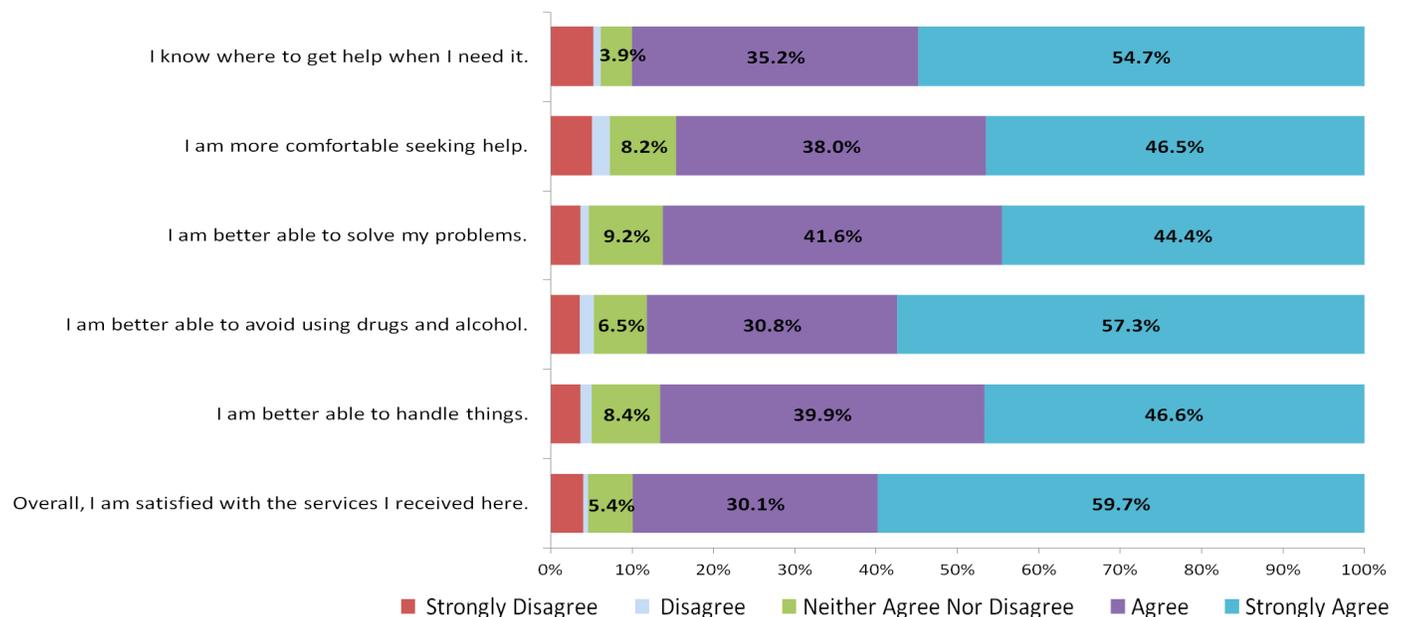
Note. 185 participants did not provide race/ethnicity and were excluded

## PARTICIPANT OUTCOMES

Although more work is needed to further examine the effect of programs in all domains of the testing instrument being used (Creating Healthy Outcomes: Integrated Self-Assessment; CHOIS), preliminary results show that PEI ADS programs are making an important impact on treatment and recovery. The potential range for the Depression, Anger, Anxiety, Memory Problems, Psychosis, and Strengths subscales is 0 to 4 (Likert items ranging from “Never” to “Always”), and the potential range for the Substance Use subscale is 0 to 3 (Likert items ranging from “Never” to “Past Month”). The Overall Mental Illness subscale represents the mean of every item within the Depression, Anger, Anxiety, Memory Problems, Psychosis, and Substance Use subscales. In each of the subscales, with the exception of Strengths, lower ratings indicate reduced mental illness symptoms. For the Strengths subscale, higher scores indicate greater resilience and protective factors.



Upon completion of the program, participants are asked six questions regarding their satisfaction with the program, and how the program helped them. These items were only given to participants who completed the intervention, and the number of respondents varied for each item. Most participants “Strongly Agreed” or “Agreed” that as a result of the program, “I know where to get help when I need it” (89.9%), “I am more comfortable seeking help” (84.5%), “I am better able to solve my problems” (86.0%), “I am better able to avoid using drugs and alcohol” (88.1%), and “I am better able to handle things” (86.5%). Overall, 89.8% of the participants were satisfied with the additional mental health services.



This report was prepared by the HEALTH SERVICES RESEARCH CENTER at University of California, San Diego, a non-profit research organization within the Department of Family and Preventive Medicine. HSRC works in collaboration with the Performance Outcomes and Quality Improvement Unit of San Diego County Behavioral Health Services to evaluate and improve mental health outcomes for County residents. Our research team specializes in the measurement, collection and analysis of health outcomes data used to help improve the behavioral health care system and, ultimately, to improve client quality of life. For more information about HSRC please contact Andrew Sarkin, PhD at 858-622-1771.





## Elder Multicultural Access and Support Services

OA01 – Central and North Inland  
Regions, Districts 1, 2, 5

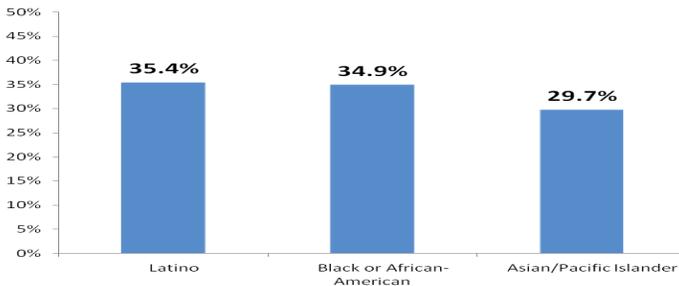


The Prevention and Early Intervention (PEI) Elder Multicultural Access and Support Services (EMASS) program provides multicultural outreach, education, advocacy, peer support, and transportation services to older Latinos, Filipinos, African refugees, and African American adults. This program is implemented by the Union of Pan Asian Communities (UPAC), in partnership with the National Alliance on Mental Illness (NAMI) of San Diego County, and the Somali Family Services of San Diego. Utilizing the “Promotoras Model,” an identified best

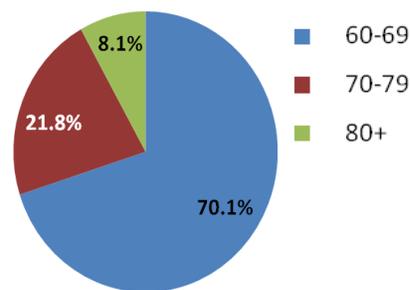
practice model to outreach underserved and un-served communities, EMASS offers educational/support sessions about medications management, grief, and mental health.

EMASS was funded by the Mental Health Services Act (MHSA). Originally passed by voters as Proposition 63, the MHSA became state law, effective January 1, 2005. MHSA funding gives counties a unique opportunity to implement programs to help prevent the onset of mental illness or to provide early interventions to help decrease severity.

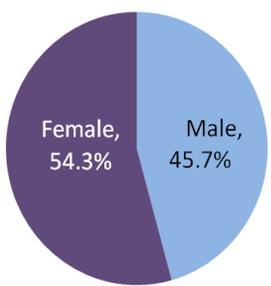
**Race/Ethnicity**



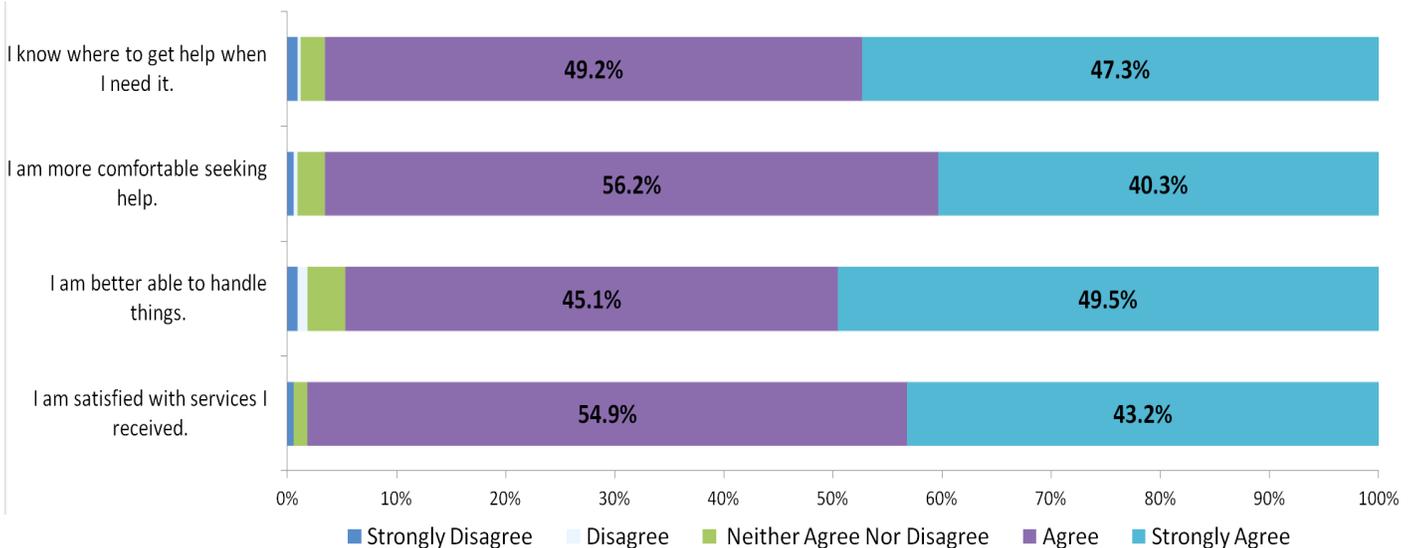
**Age**



**Gender**



### Program Satisfaction



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# Positive Solutions

OA02 – Central and North Coastal  
Regions, Districts 1, 5  
Union of Pan Asian Communities



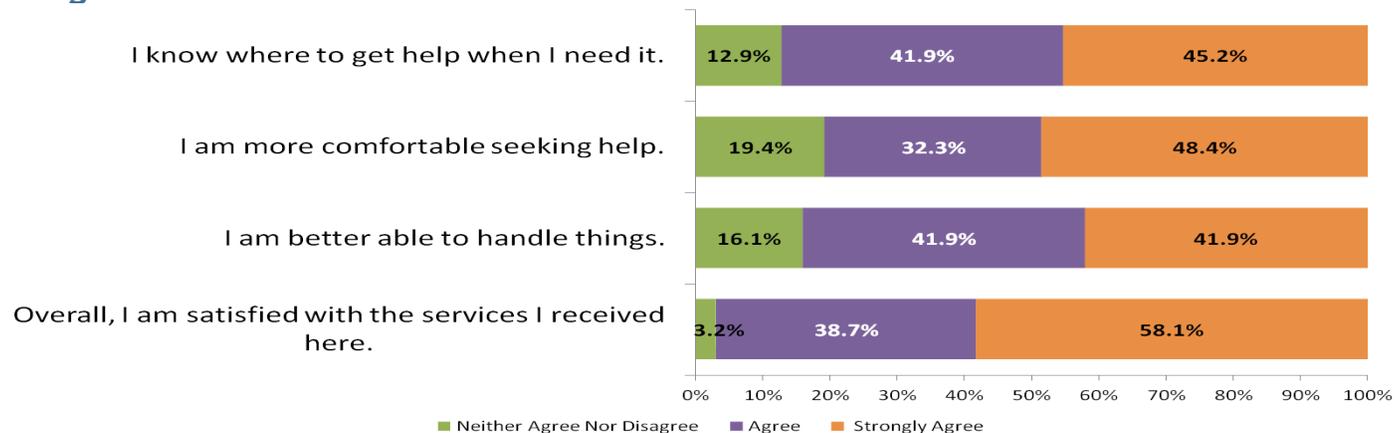
In San Diego County, in the year 2000, almost 15% of the total population was aged 60 and over. San Diego County older adults have a higher risk of committing suicide than any other age group. According to data from the Centers for Disease Control, the suicide rate among older adults in San Diego has been generally higher (27.6%) than in the State of California (23.7%) and the United States (18.5%) since 1979 (Community Health Improvement Partners Report on Suicide in San Diego, 2004). Depression and suicide in older adults have a strong correlation; therefore identifying and treating depression is an essential strategy for reducing risk of suicide.

The goals of the Positive Solutions program, part of the Prevention and Early Intervention (PEI) plan, are to increase knowledge of depression symptoms and suicide risk, provide education and support to reduce stigma, and to promote linkage with services and supports. The target population includes racially, ethnically and culturally diverse older adults who are underserved, and are at risk for depression, medication misuse, and substance abuse. Services provided address needs of at-risk homebound seniors for prevention and early intervention, and those less likely to seek traditional mental health services.

This program combines evidence-based practices to deliver multicultural, gender sensitive, in-home PEI Services to older adults in San Diego County. PEI services include outreach, education, depression screening, mental health assessment, suicide risk assessment, brief intervention, counseling, linkage, referral to community resources and follow-up. The Home Based PEI Gatekeeper Program and the Meals on Wheels Mental Health Outreach Program are two components used to identify and recruit at-risk individuals, and those in need of aging and/or mental health services. Brief interventions are delivered by the PEI Program Specialist to help reduce depressive symptoms and increase social activities. The PEI Program Specialist may also provide referral and linkages to additional service providers. Senior Peer Counselors provide supportive counseling services and companionship to reduce isolation and depression risk.

Positive Solutions is one of many programs implemented as a result of the Mental Health Services Act (MHSA). Originally passed by voters as Proposition 63, the MHSA became state law, effective January 1, 2005. MHSA funding gives counties a unique opportunity to implement programs to prevent the onset of mental illness or to provide early intervention to help decrease severity.

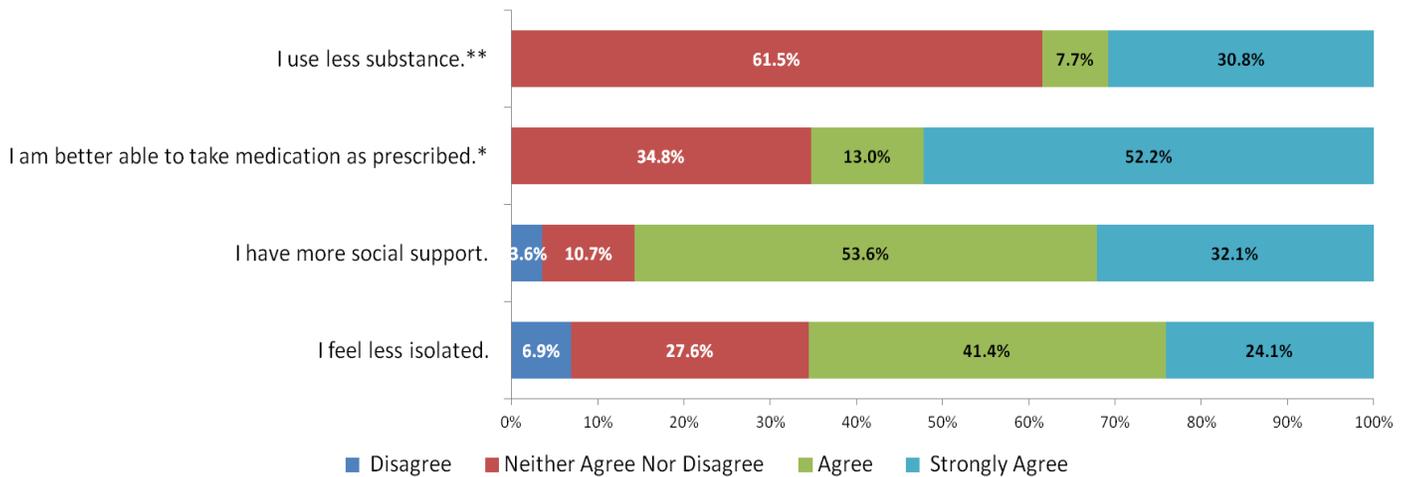
## Program Satisfaction



Participants were asked to assess both their improvement in several areas and their satisfaction with the Positive Solutions program. These items were assessed only for the 31 participants who completed the intervention. A majority of the participants either “Agreed” or “Strongly Agreed” that because of the intervention, “I know where to get help when I need it” (87.1%), “I am more comfortable seeking help” (80.7%), “I am better able to handle things” (83.8%), and “Overall, I am satisfied with the services I received here” (96.8%).

## Program Specific Outcomes

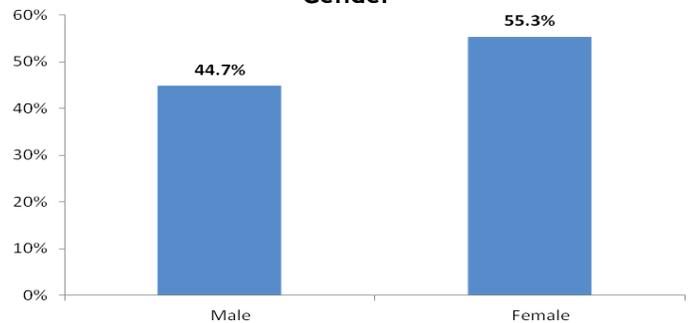
Positive Solutions participants also assessed the benefits they received from the program. These items were again only assessed for participants who completed the intervention, and the number of respondents varied for each item. Over a quarter of participants “Agreed” or “Strongly Agreed” that, “I use less substance” (38.5%). A majority of the participants either “Agreed” or “Strongly Agreed” that because of Positive Solutions, “I am better able to take prescription medication as prescribed” (65.2%), “I have more social support” (85.7%), and, “I feel less isolated” (65.5%).



## Participant Demographics

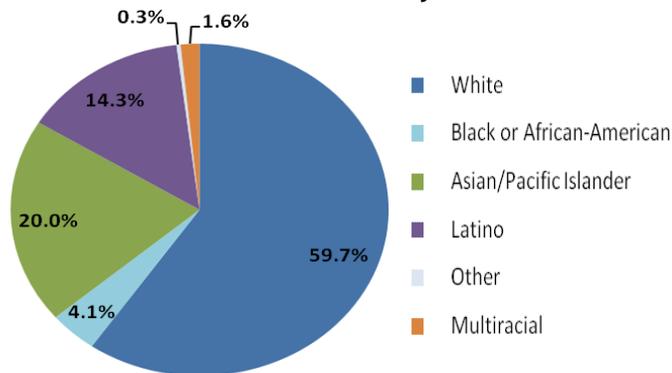
During Fiscal Year (FY) 2012-13, Positive Solutions provided services to 924 participants. The majority of the participants were female (55.3%), White (59.7%) or Asian/Pacific Islander (20.0%), and 70 or older (75.0%). Of the Latino/Hispanic participants who reported their origin, a large portion were Mexican American/Chicano (60.6%). Almost a quarter of participants served in the military (22.8%) with the majority having served in the Army (28.6%)

### Gender



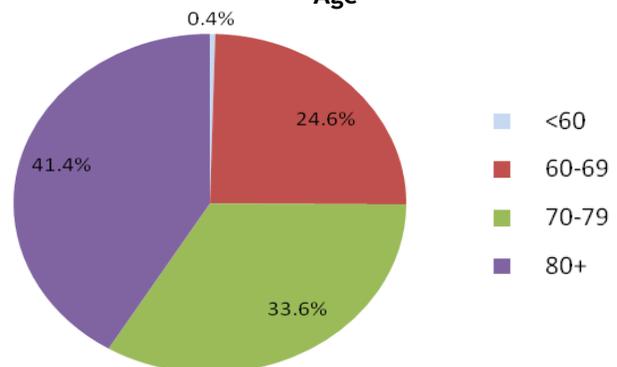
Note. 11 participants did not report gender and 1 participant reported 'Other' and were excluded

### Race/Ethnicity



Note. 53 participants did not report race/ethnicity and were excluded  
1 participant reported race/ethnicity as 'Native American'

### Age



Note. 15 participants did not report age and were excluded

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## Resource for enhancing Alzheimer's Caregiver Health (REACHing Out)

OA04— North Central Region, District 4  
University of California, San Diego



## Development of the REACH Intervention

*5.2 million Americans over the age of 65 have Alzheimer's Disease (AD), and the incidence is expected to increase, particularly for Hispanics in the United States. \**

Caregivers of Alzheimer's Disease (AD) patients have been shown to suffer from high rates of depression, physical illness, psychotropic medication use, social isolation, health care utilization, sleep problems and decreased quality of life.

To combat the physical and emotional strain put on caregivers of AD patients, the National Institutes of Health granted funding to several universities to develop interventions to help family caregivers. This initiative began in 1995, and led to the development of the Resources for Enhancing Alzheimer's Caregiver Health (REACH) program. The REACH program is an evidence-based, multi-component intervention that provides resources and emotional support to caregivers of AD patients. The goal of REACH is to prevent or reduce symptoms of depression that manifest from the isolation and the burden of care often experienced by this vulnerable population. Many types of existing home and community based interventions were tested across the country, and the most successful methods became the model for the REACH program.

To improve the quality of life for the growing population of AD patients and caregivers, the County of

San Diego Health and Human Services Agency (HHS) Behavioral Health Services contracted with Southern Caregiver Resource Center (SCRC) to implement the REACHing Out program, as part of the Prevention and Early Intervention (PEI) Plan.

Research has demonstrated that the health outcomes for Hispanic caregivers are worse than other groups. These poor health outcomes are attributed to the disproportionate share of AD care performed by family members, and a reluctance to utilize formal care. Since San Diego County has a large Hispanic population, SCRC tailored the program to address the specific needs of this population. Behavior management, communication, stress management, and relaxation techniques are emphasized.

REACHing Out is among many programs implemented as a result of the Mental Health Services Act (MHSA). Originally passed by voters as Proposition 63, the MHSA became state law, effective January 1, 2005. MHSA funding gives counties a unique opportunity to implement programs to prevent the onset of mental illness or to provide early intervention to help decrease severity.

\*Source: Alzheimer's Association (2011). Alzheimer's Disease Facts and Figures, Alzheimer's & Dementia, Volume 7, Issue 2.

### Southern Caregiver Resource Center

SCRC is a private, independent non-profit organization that helps families and caregivers by providing services that are inclusive of all issues related to caring for adults with chronic and/or disabling conditions.

SCRC offers two levels of REACH intervention. The first is a small group psychoeducational intervention, which consists of four two-hour program sessions. Group sessions address the stigma associated with mental health, and use instruction and

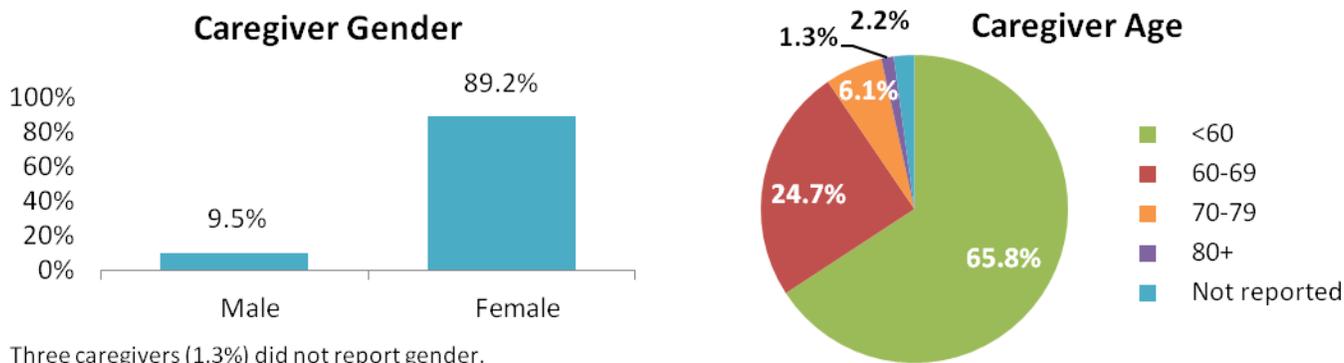
practical exercises to teach specific cognitive and behavioral skills.



The second type of intervention is home based, and is available to family caregivers who would benefit more from a one-on-one intervention. This intervention consists of four 2-hour, in-home psychoeducational sessions, and three additional telephone follow up contacts, with the topics customized based on a caregiver assessment.

## Demographics of Caregivers (REACH Clients)

During Fiscal Year (FY) 2012-13, SCRC enrolled 231 Hispanic caregivers into the REACHing Out program. The majority of participants in the program are Female (89.2%), of Mexican origin (89.8%), and under 60 years old (65.8%).

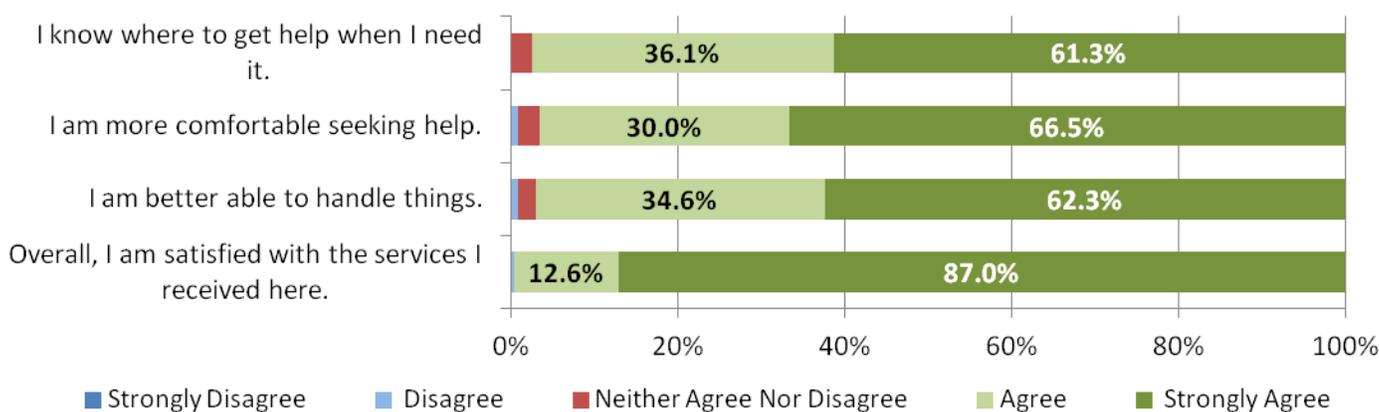


Health conditions such as high blood pressure and diabetes, lower levels of education and other differences in socioeconomic characteristics that are risk factors for AD are more common in older African-American and Hispanics than in older whites.

Alzheimer's Association, 2011 Alzheimer's Disease Facts and Figures, *Alzheimer's & Dementia*, Volume 7, Issue 2.

## Program Satisfaction

Caregivers were asked to complete several items to assess the perceived benefits of the REACH intervention. Almost all of the caregivers "Agreed" or "Strongly Agreed" that because of the intervention, "I know where to get help when I need it" (97.4%), "I am more comfortable seeking help" (96.5%), "I am better able to handle things" (97.0%), and "Overall, I am satisfied with the services I received here" (99.6%).



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# Salud

OA05 – South, N. Coastal, and N. Inland  
Regions, Districts 1, 5  
N. County Health Services (NCHS), San  
Ysidro Health Center (SYHC), and UCSD



The Prevention and Early Intervention (PEI) Salud program targets the high prevalence of comorbid diabetes and depression evident among Hispanic elderly through a partnership between the County of San Diego Behavioral Health Services, San Ysidro Health Center (SYHC), North County Health Services (NCHS), and the University of California, San Diego (UCSD).

The Salud program targets unserved or underserved Hispanic older adults, 60 years of age and over with a diagnosis of diabetes and with symptoms of depression and/or at risk of developing depressive symptoms. Early Intervention includes integrated diabetes/depression care management including both diabetes care and depression care. Intervention is delivered in primary care settings.

All Salud program participants take part in the Diabetes Self-Management Program (DSMP), an evidence-based practice treatment approach designed to provide patients with the knowledge and skills needed to better manage their diabetes through six weekly group

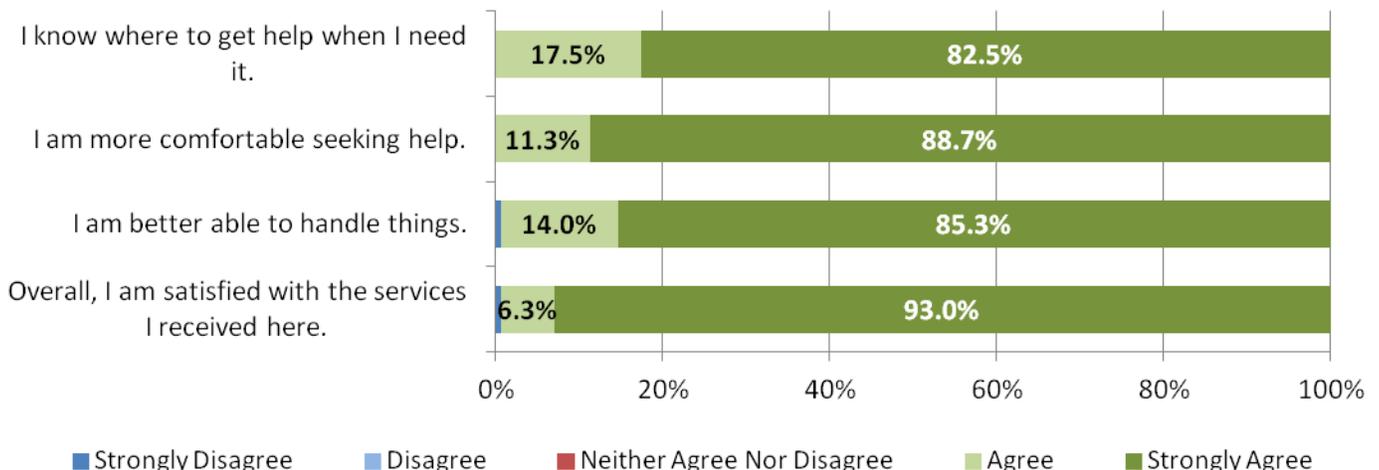
workshops. Participants make weekly action plans, share experiences, and help each other solve problems they encounter in creating and carrying out their self-management program.

In addition, patients from SYHC have access to a care coordinator who monitors their diabetes and mental health concerns and engages them in Problem Solving Therapy (PST) to help treat their depressive symptoms. The program design supports the development of integrated care for diabetic participants experiencing depression by assigning responsibility for mental health and medical care to one single care provider.

Salud is one of many programs implemented as a result of the Mental Health Services Act (MHSA). Originally passed by voters as Proposition 63, the MHSA became state law, effective January 1, 2005. MHSA funding gives counties a unique opportunity to implement programs to prevent the onset of mental illness or to provide early intervention to help decrease severity.

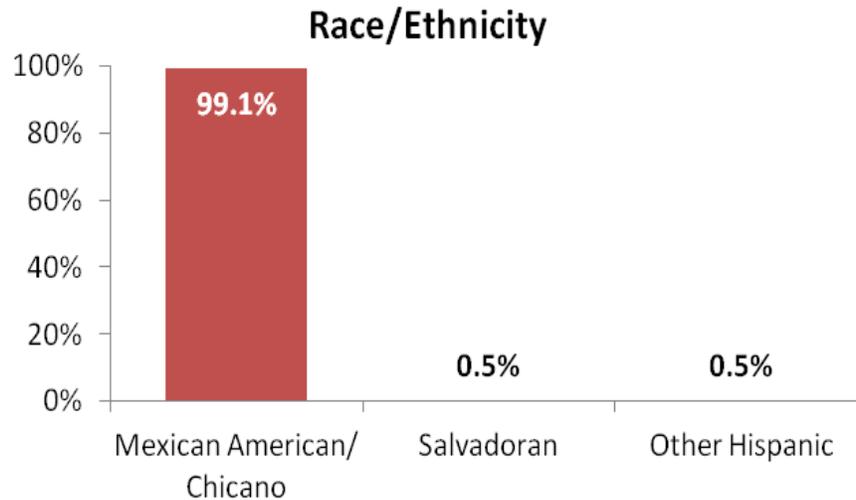
## Program Satisfaction

Upon completing the Salud program, participants are asked to assess the perceived benefits of the program. Of the 221 enrolled participants, 143 have completed the program and the assessment. A majority of these participants “Agreed” or “Strongly Agreed” that because of the intervention, “I am better able to handle things” (99.3%), and “Overall, I am satisfied with the services I received here,” (99.3%). All of the participants “Agreed” or “Strongly Agreed” that because of the intervention, “I know where to get help when I need it,” and “I am more comfortable seeking help,” (both 100.0%).

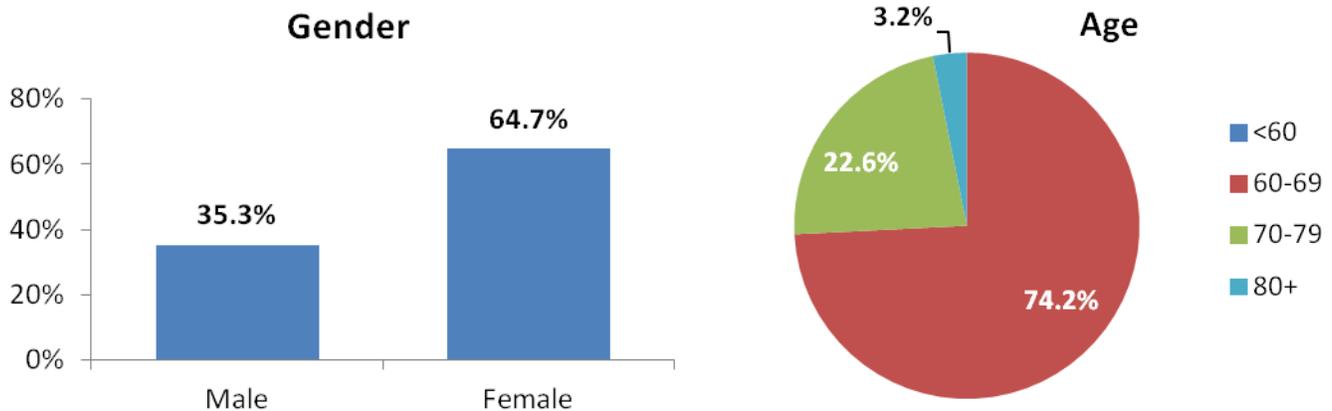


## Participant Demographics

During Fiscal Year (FY) 2012-13, San Ysidro Health Center, North County Health Services, and the University of California, San Diego provided services to 221 participants through the Salud program. The Salud program is designed to target the Hispanic population in San Diego County. All but 1 of the participants (95.5%) identified themselves as Hispanic. The one person who did not identify themselves as Hispanic identified themselves as Native American. Almost all of the participants were Mexican American/Chicano (99.1%), and 1.0% were Salvadoran or other Hispanic.



The majority of the participants in the program were female (64.7%), and aged 60-69 (74.2%). The mean age of the participants was 65.9. A small proportion of the participants had served in the military (0.9%).



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# Breaking Down Barriers

PS01C – Central, East, South, North Coastal, North Inland, North Central Regions, All Districts  
Mental Health Association



The Prevention and Early Intervention (PEI) Breaking Down Barriers program uses a Cultural Broker outreach model to create effective collaborations with various agencies, community groups, participant and family member organizations, and other stakeholders to reduce mental health stigma and increase access to mental health services by unserved and underserved culturally-diverse communities.

A Cultural Broker is a person known in the local community, engaged to provide outreach and engagement support with existing agencies.

The term “culturally diverse” refers to both racial/ethnic and non-racial/ethnic groups. The former includes Latinos, Native Americans, Asian Americans, African Americans, and people from the Pacific Islands. The latter includes—but is not limited to—those with disabilities (blind and vision impaired, deaf and hard of hearing, or persons who are otherwise physically challenged), gay, lesbian, bisexual, and transgendered persons, transition age youth and older adults.

The Breaking Down Barriers Program provides prevention and early intervention services through the

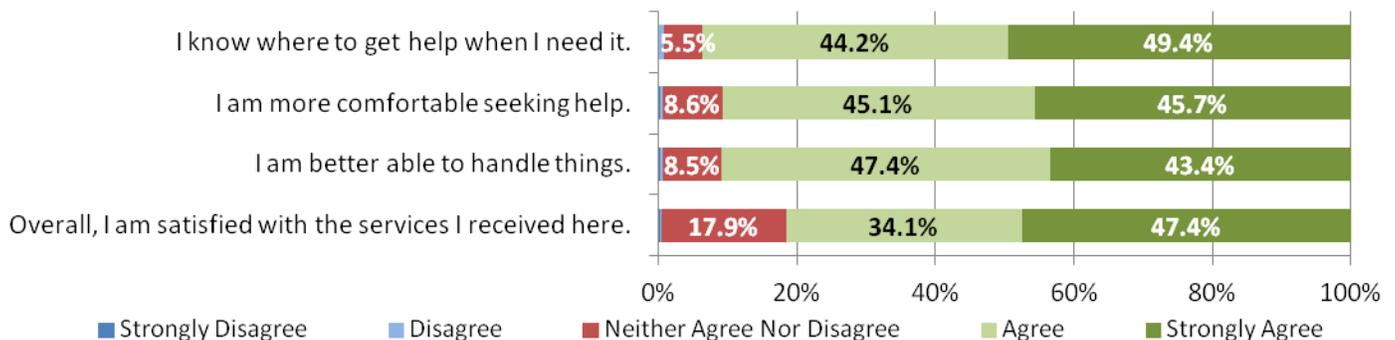
efforts of Cultural Brokers to:

- Provide mental health outreach, engagement and education to persons in the Latino, Native American (Rural and Urban), Lesbian/Gay/Bisexual/Transgender/Queer, African, and African American communities;
- Implement and evaluate strategies to reduce mental health stigma; and
- Create effective collaborations with other agencies, community groups, participants, and family member organizations.

The program provides information on various topics related to mental health (for example, depression, teen stress, and bereavement). Topics presented are dependent upon and modified to best fit the needs of each individual community.

Breaking Down Barriers is one of many programs implemented as a result of the Mental Health Services Act (MHSA). Originally passed by voters as Proposition 63, the MHSA became state law, effective January 1, 2005. MHSA funding gives counties a unique opportunity to implement programs to prevent the onset of mental illness or to provide early intervention to help decrease severity.

## PEI Outcomes and Satisfaction

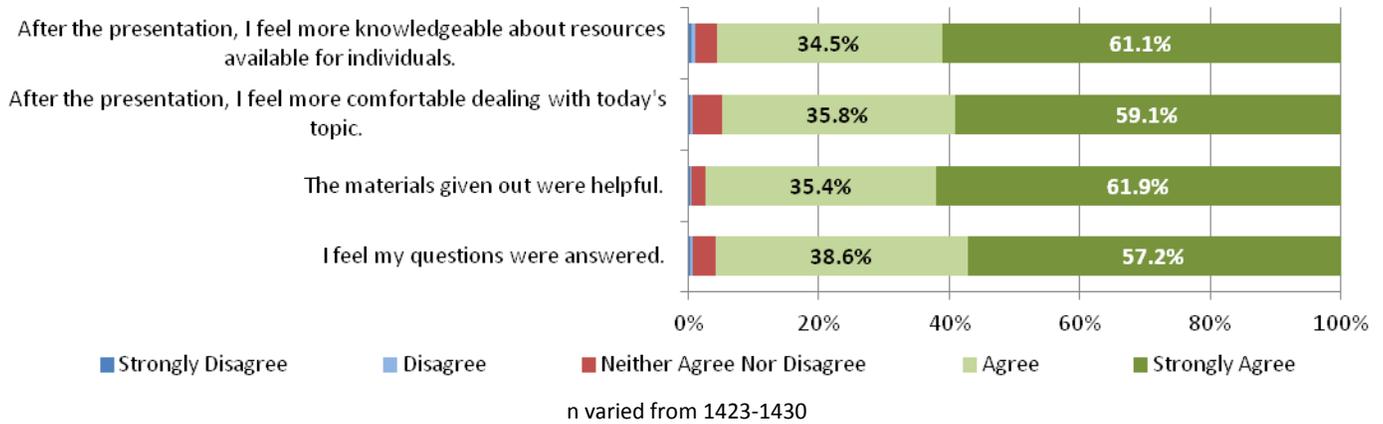


n varied from 1404-1408

Participants were asked to assess their improvement in several areas of interest, and their satisfaction with the Breaking Down Barriers intervention. These items were only given to participants who completed the intervention, and the number of respondents varied for each item. A majority of the participants either “Agreed” or “Strongly Agreed” that because of the intervention, “I know where to get help when I need it” (93.7%), “I am more comfortable seeking help” (90.8%), “I am better able to handle things” (90.8%), and “Overall, I am satisfied with the services I received here” (81.5%).

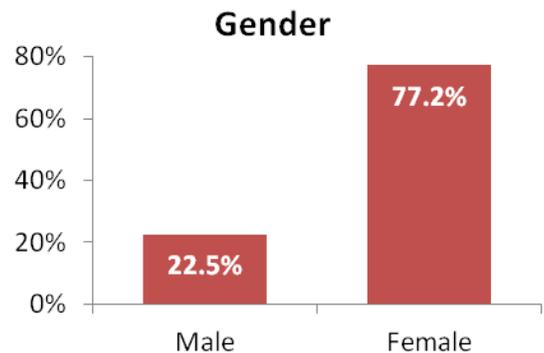
## Program Specific Outcomes

Participants who participated in Breaking Down Barriers presentations assessed the effectiveness of the program's presentations. These items were also only given to participants who completed the intervention, and the number of respondents varied for each item. A majority of the participants either "Agreed" or "Strongly Agreed" with the statements, "After the presentation, I feel more knowledgeable about resources available for individuals" (95.7%), "After the presentation, I feel more comfortable dealing with today's topic" (94.9%), "The materials given out were helpful" (97.3%), and, "I feel my questions were answered" (95.8%).

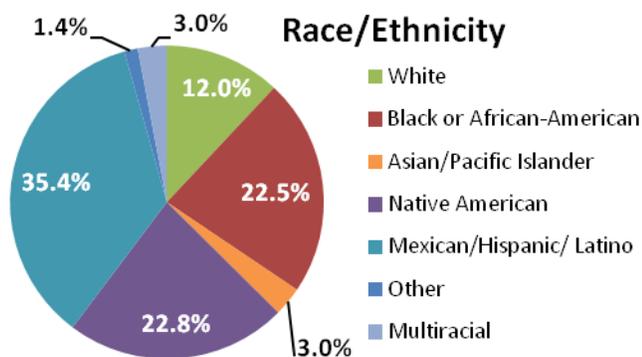


## Participant Demographics

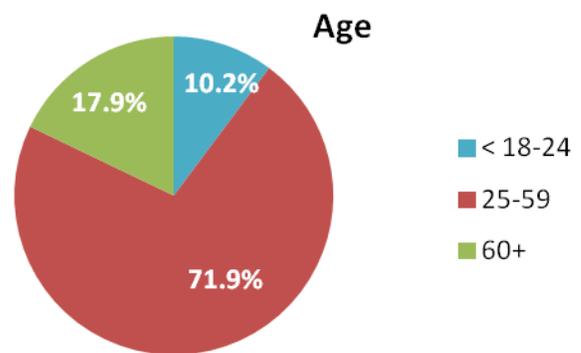
During Fiscal Year (FY) 2012-13, Breaking Down Barriers provided services to 1,472 participants. The majority of the participants who received services were female (77.2%). Hispanic or Latino (35.4%), Black or African American (22.5%) and Native American (22.8%) made up the largest racial/ethnic groups receiving services. Of Hispanic and Latino participants, a majority were Mexican American/Chicano (76.1%). About a third of all participants (30.0%) did not report their age. Of those who did, the majority were 25-29 years old (71.9%). A smaller percentage of participants was 60 and above (17.9%). A very small percentage of participants had served in the military (5.0%).



4 (0.3%) reported gender as "other"  
23 did not report gender and were excluded



35 did not report race/ethnicity and were excluded



442 did not provide age and were excluded

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# Project Enable

PS01E—Central Region, District 4  
Neighborhood House Association



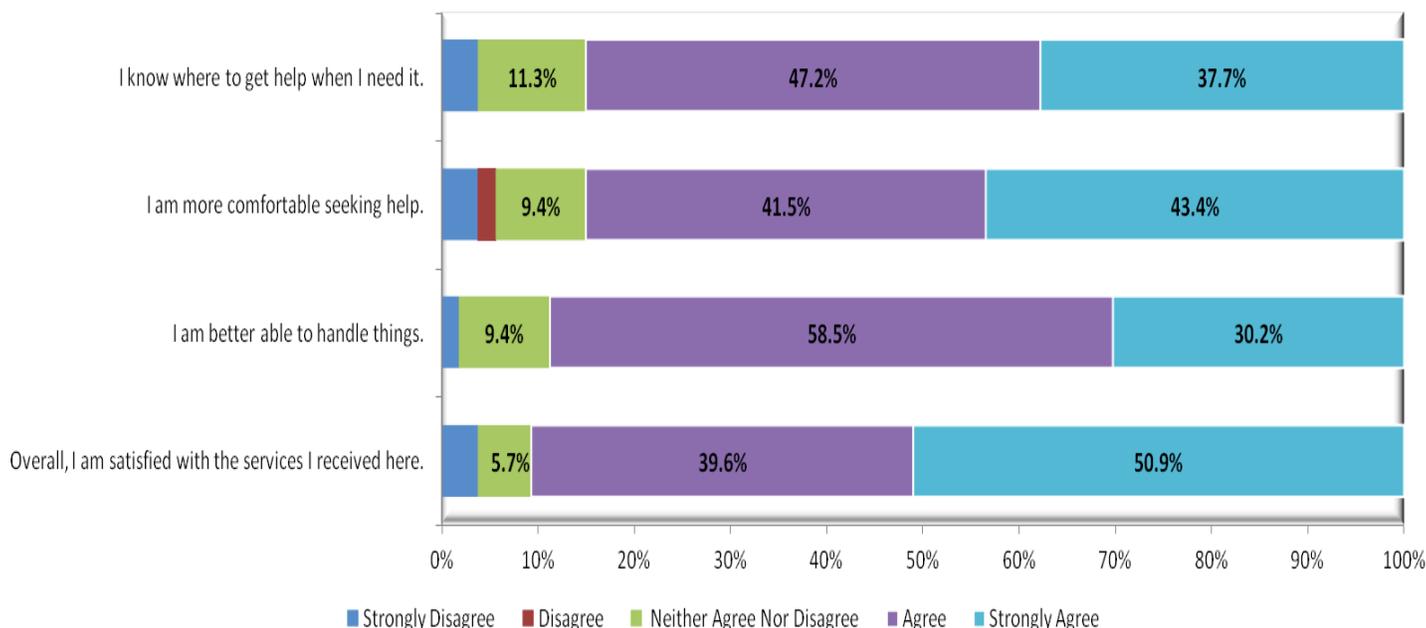
Neighborhood House Association via Project Enable provides MHSA Prevention and Early Intervention (PEI) funded services via In-Reach Services primarily to at risk African-American and Latino citizens who are residents of San Diego County and who are incarcerated adults or transitional-age youth (TAY) at designated detention centers. Services include in-reach, engagement; education; peer support; follow-up after release from detention centers and linkages to services that improve participant’s quality of life; diminish risk of recidivism; and diminish impact of untreated health, mental health and/or substance abuse issues.

A Bio-Psychosocial Rehabilitation (BPSR) Wellness and Recovery Center provides time-limited outpatient specialty mental health services to adults 18 years of age and older

who are affected by serious and persistent mental illness and/or co-occurring disorders that interfere with their ability to function in key life roles, as parents, students, spouses and employees. The program strives to reduce psychiatric symptoms and the need for hospitalization while rehabilitating clients to their highest level of functioning.

Project Enable is one of many programs implemented as a result of the Mental Health Services Act (MHSA). Originally passed by voters as Proposition 63, the MHSA became state law, effective January 1, 2005. MHSA funding gives counties a unique opportunity to implement programs to prevent the onset of mental illness or to provide early intervention to help decrease severity.

## Program Satisfaction

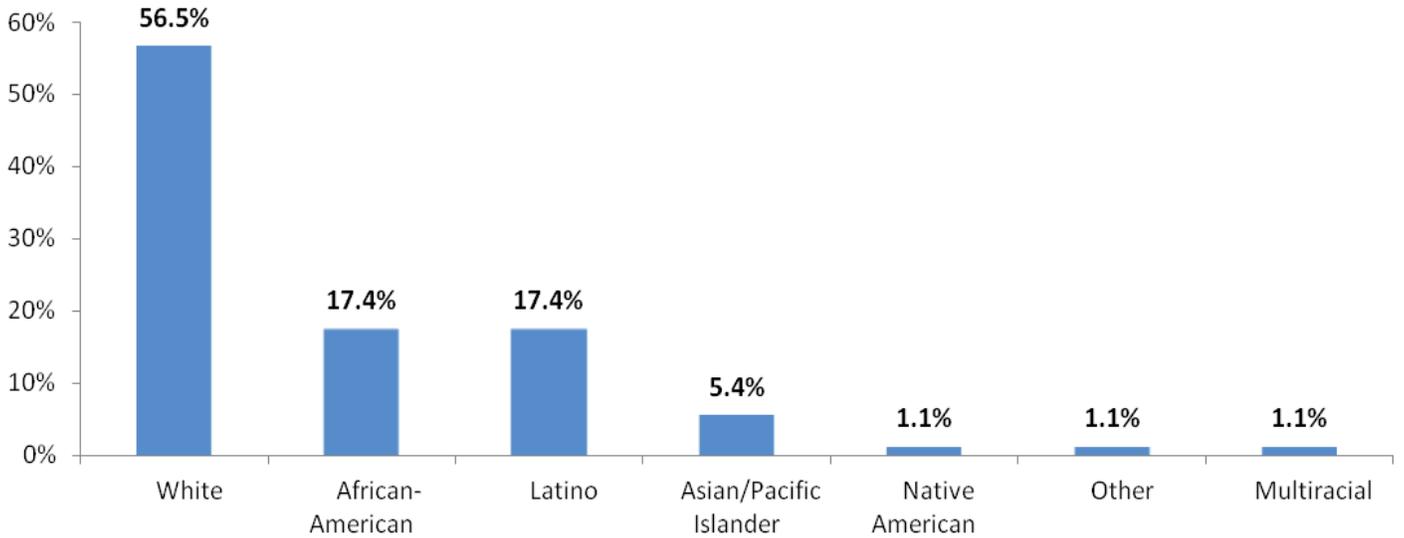


Participants were asked to assess the perceived benefits and their overall satisfaction with the Project Enable/In-Reach program. Of the 92 participants enrolled in the program, 53 participants completed the satisfaction survey. A majority of participants either “Agreed” or “Strongly Agreed” that because of the intervention, “I know where to get help when I need it” (84.9%), “I am more comfortable seeking help” (84.9%), “I am better able to handle things” (88.7%), and “Overall, I am satisfied with the services I received here” (90.5%).

## Participant Demographics

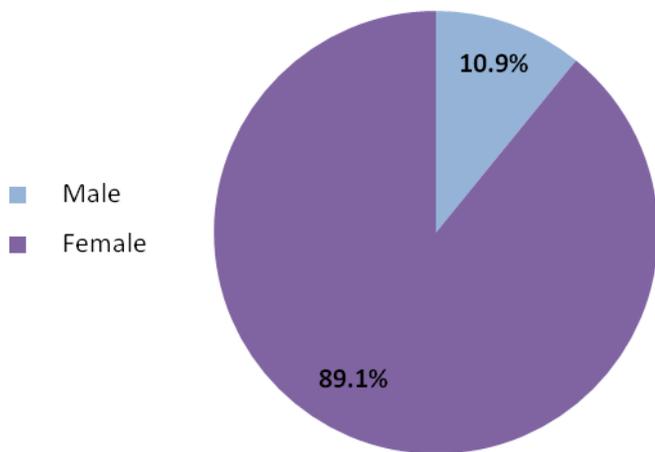
During Fiscal Year (FY) 2012-13, Neighborhood House Association provided services to 92 participants through Project Enable. One of the goals of Project Enable is to provide services primarily to at-risk African-American and Latino adults incarcerated in San Diego County. Most participants were either White (56.5%), African-American (17.4%), or Latino (17.4%). Of those participants who reported Latino origin, the majority (82.4%) were Mexican-American or Chicano.

Race/Ethnicity

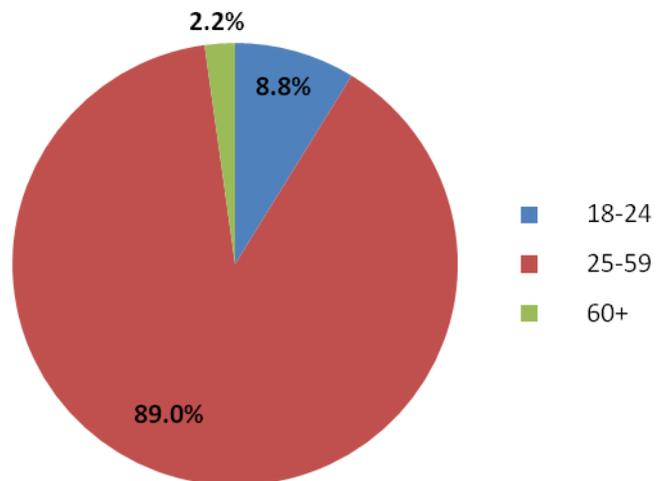


The majority of the participants in the program were female (89.1%), and aged 25-59 (89.0%). The mean age of the participants was 38.5. A small proportion of the participants reported military service (3.3%).

Gender



Age



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# Adult/Family Peer Support Line

PS01G – Central, East, South, N. Coastal, N. Inland, N. Central Regions, Districts 1-5

National Alliance of Mental Illness (NAMI)



The goal of the Primary and Secondary Prevention (PS01) portion of the Prevention and Early Intervention (PEI) plan is to increase public awareness and understanding of mental illness through media-based outreach and education campaigns. This two-pronged approach also seeks to provide outreach and education to targeted underserved and un-served populations.

A means of providing outreach and education for PEI occurs via the confidential Adult/Family Peer Support Line supported by the National Alliance on Mental Illness (NAMI) San Diego. NAMI San Diego is part of the grass-roots, non-profit, national NAMI organization founded in 1979 by family members of people with mental illness. This Family Peer Support Line was established to provide countywide non-crisis support, mental health education, and referral services for families, friends and those affected by serious mental illness.

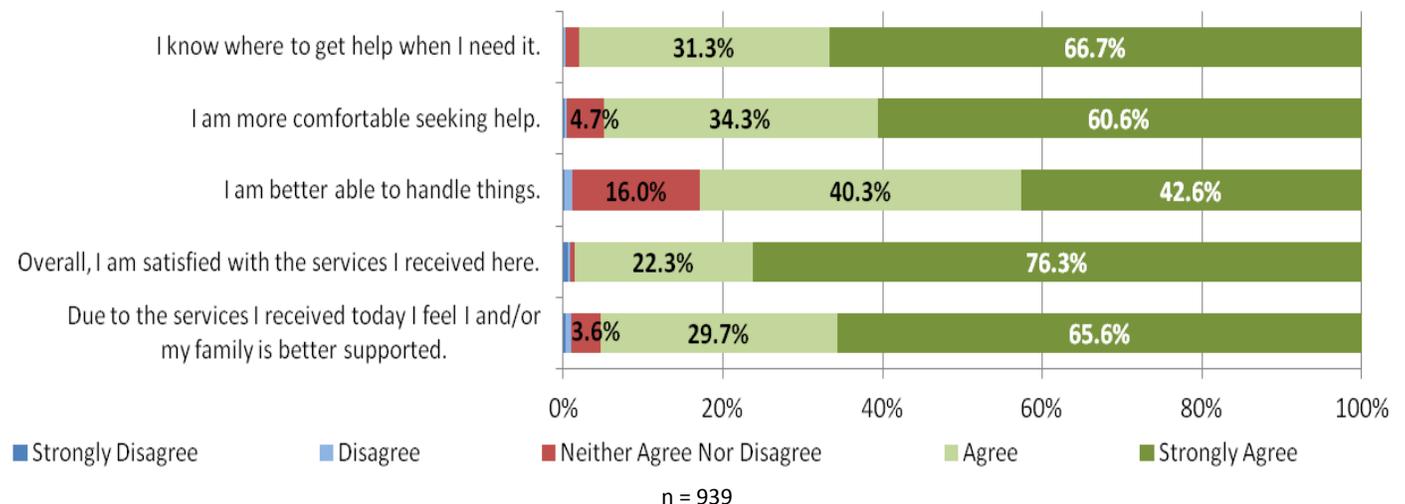
The support line is staffed by family members of individuals affected by mental illness who are trained to provide culturally competent support and resources. Individuals calling the NAMI helpline receive information about classes and support groups offered, as well as additional

information about mental health related resources. **The NAMI Support line can be reached at (619) 543-1434.**

The Adult/Family Peer Support Line is one of many programs implemented as a result of the Mental Health Services Act (MHSA). Originally passed by voters as Proposition 63, the MHSA became state law, effective January 1, 2005. MHSA funding gives counties a unique opportunity to implement programs to prevent the onset of mental illness or to provide early intervention to help decrease severity.

After providing individuals with the information they need, support line staff asked callers several questions including demographics and their satisfaction with the Adult/Family Peer Support Line services. Data presented in this report include information about the individual who made the call to the support line, the ‘caller,’ and information about the individual who will be receiving the mental health services, the ‘consumer.’ In some cases, the caller may request information for themselves, whereas in other cases the caller may request information for a family member or friend in need.

## PEI Outcomes and Satisfaction

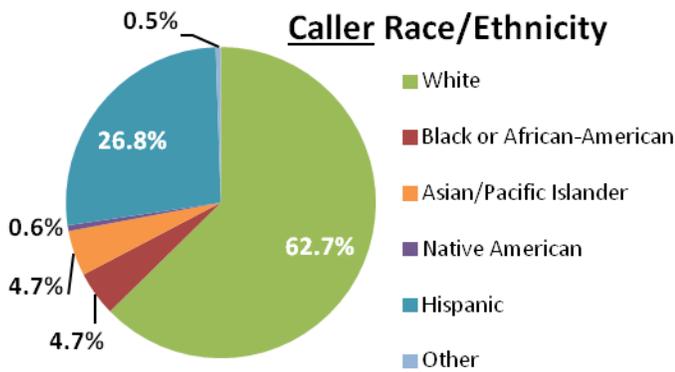


Participants were asked to assess their improvement in several areas of interest, and their satisfaction with the Adult/Family Peer Support Line. The number of respondents varied for each item. A majority of participants either “Agreed” or “Strongly Agreed” that because of the intervention, “I know where to get help when I need it” (98.0%), “I am more comfortable seeking help” (94.9%), “I am better able to handle things” (82.9%) and, “Overall, I am satisfied with the services I received here” (98.5%). A majority of participants either “Agreed” or “Strongly Agreed” that, “Due to the services I received today, I feel I and/or my family is better supported” (95.3%).

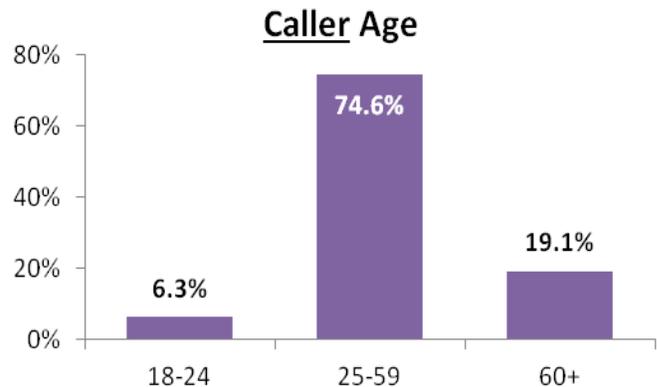
## Participant Demographics

During Fiscal Year (FY) 2012-13, Adult/Family Peer Support Line provided services to 4,410 callers. Of those callers who reported their information\*, the majority were female (73.3%), white (62.7%), and between 25 and 59 years old (74.6%). A very small percentage of callers had served in the military (2.9%). Of those consumers for whom data were available\*, the majority were between 25 and 59 years old (68.0%). White consumers were the largest racial/ethnic group served (67.5%). There was approximately an equal proportion of male and female consumers (50.7% and 49.3%, respectively). Data on specific Hispanic origin, consumer military service or service branch were not collected for this program.

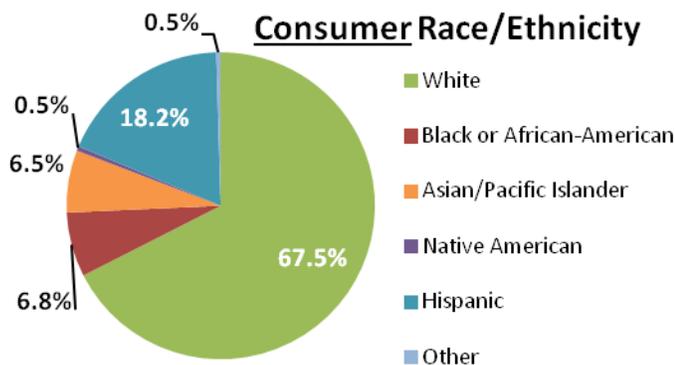
\* Gender data were not reported for 1,154 callers and 3,343 consumers. Information on non-reported data for race/ethnicity and age for callers and consumers is provided in the charts below.



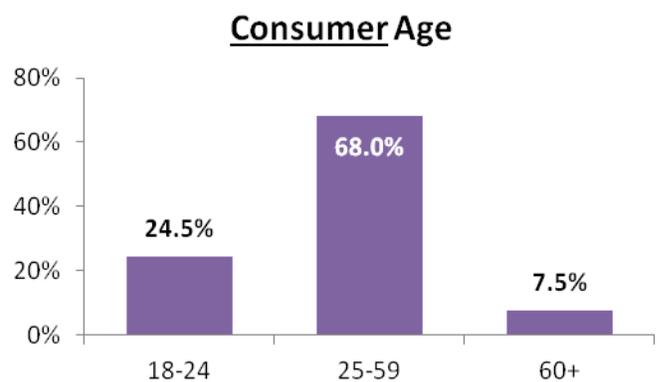
2,889 did not provide race/ethnicity and were excluded



2,394 did not provide age and were excluded



3,982 did not provide race/ethnicity and were excluded



3,798 did not provide age and were excluded

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# Courage to Call

VF01—Central, East, South, North Coastal, North Inland, and North Central  
Regions, Districts 1-5  
National Alliance of Mental Illness (NAMI)



The Veterans, Active Duty Military, Reservists, National Guard and their Families (VMRGF) population in San Diego County is increasing annually with the return of troops from Operation Enduring Freedom (OEF; Afghanistan) and Operation Iraqi Freedom (OIF; Iraq). The percentage of military personnel returning from Afghanistan and Iraq with mental health concerns and PTSD ranges from 17-27% and 15-24%, respectively. Additionally, the suicide rate for those returning from deployment is 49% above the national average. Although the incidence of mental health issues is high in the VMRGF population, 58% returning from war with mental health concerns do not seek treatment (National Center for PTSD, Department of Veterans Affairs, 2011). Aside from the direct impact of mental illness on the individual, the impact on familial relationships may extend the consequences of combat-related mental health problems across generations.

The Prevention and Early Intervention (PEI) Veterans and their Families program (VF01) focuses on populations not served, or whose needs are not met by traditional veteran and active duty military service providers. The potential target population of this PEI program is in excess of 1,000,000, roughly 1/3 of San Diego County (San Diego MHSA PEI Plan, 2008). Specifically, the VF01 program provides education to VMRGF on relevant mental health topics, and peer counseling

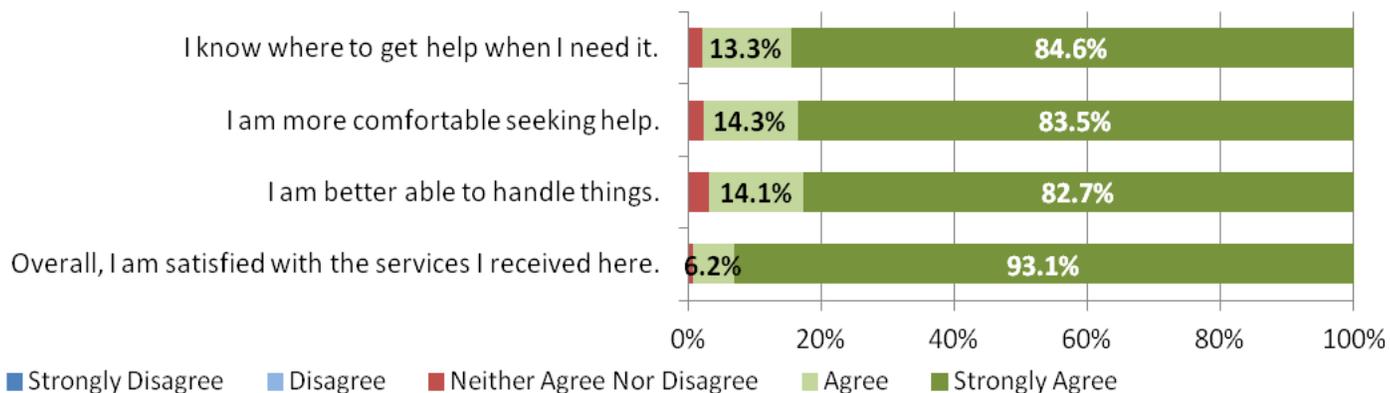
to reduce mental health risk factors or stressors. Education and training is also offered to providers serving the VMRGF community (behavioral and primary health care providers, businesses, faith-based organizations, schools and colleges/universities, law enforcement, and justice system) to improve understanding of the military culture and improve recognition of mental health issues unique or relevant to the VMRGF.

The VF01 program also provides free comprehensive information 24 hours a day, 7 days a week to VMRGF, outside of military channels, via the Courage to Call telephone helpline. The helpline is staffed with veterans who provide mental health information, self screening tools and appropriate resources, as well as help with establishing linkages to mental health services.

Courage to Call staff follow up with all callers to ensure that individuals are able to access the services they need. During the follow-up call, individuals are asked to participate in a short survey regarding their satisfaction with the Courage to Call helpline. The data presented in this report reflect only those 780 callers who agreed to participate in the survey during Fiscal Year (FY) 2012-13.

**The Courage to Call helpline can be reached at 2-1-1.**

## PEI Outcomes and Satisfaction



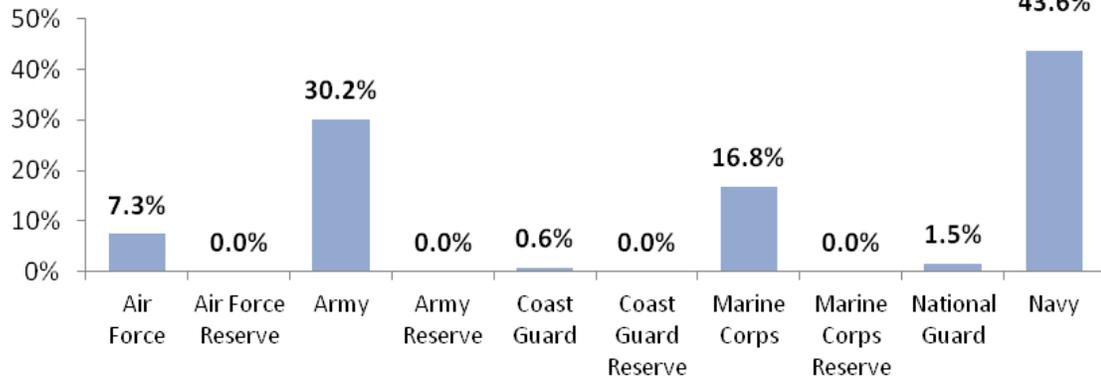
n varied from 140-141

Participants were asked to assess both their improvement in several areas and their satisfaction with the Courage to Call program. These items include participants who agreed to complete the survey and the number of respondents varied for each item. A majority of participants either “Agreed” or “Strongly Agreed” that because of the intervention, “I know where to get help when I need it” (97.9%), “I am more comfortable seeking help” (97.8%), “I am better able to handle things” (96.8%), and “Overall, I am satisfied with the services I received here” (99.3%).

## Participant Demographics

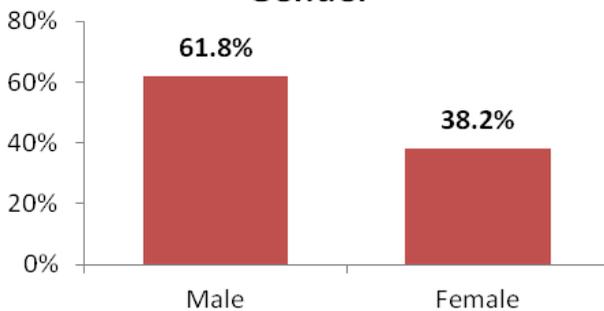
The majority of Courage to Call participants (n= 780) in FY 2012-13 who responded to the survey were male (61.8%), white (39.5%), and between 40 and 70 years old (69.6%). The vast majority of callers served in the military (61.7%), with most serving in the Navy (43.6%), the Army (30.2%), or the Marine Corps (16.8%).

### Branch of Military Served



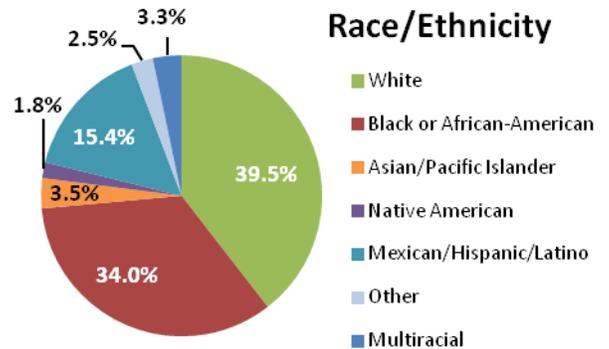
4 did not provide branch of military and were excluded

### Gender



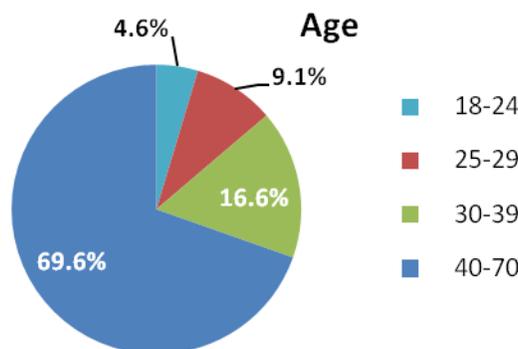
26 did not provide race/ethnicity and were excluded

### Race/Ethnicity



175 did not provide race/ethnicity and were excluded

### Age



155 did not provide race/ethnicity and were excluded

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