COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

Mental Health Services Act (MHSA) Fiscal Year 2021-22 Annual Update



Behavioral Health Services

October 5, 2021

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

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This report provides an update to the County of San Diego Health and Human Services Agency's Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan for Fiscal Year (FY) 2020-21 through FY 2022-23 (MHSA Three-Year Plan).

San Diego County Board of Supervisors



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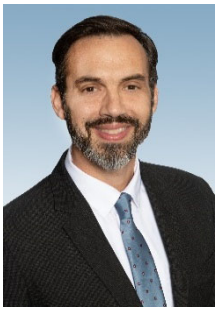
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A LETTER FROM THE BEHAVIORAL HEALTH SERVICES DIRECTOR



The Fiscal Year (FY) 2021-22 Mental Health Services Act (MHSA) Annual Update provides an opportunity for the County of San Diego Health and Human Services Agency (HHSA), Behavioral Health Services (BHS) department to inform stakeholders, partners, clients, community members, and the San Diego County Board of Supervisors of MHSA programmatic and funding priorities and changes, and highlights key accomplishments from FY 2019-20. For FY 2021-22, the County of San Diego Chief Administrative Officer's Approved Operational Plan (budget) for BHS is $817.6 million, with MHSA funding representing $218.6 million of the total BHS budget.

Though the urgency of the COVID-19 pandemic has mostly subsided, it has led to extraordinary shifts in behavioral health care and the service landscape requiring us to dramatically adjust our strategic and tactical approaches. However, we continue to press forward with our bold, cross-sectoral approach to shift how residents access care for their behavioral health needs, by transforming from a system of perpetual crisis to a regionally distributed system characterized by upstream prevention and continuous care. We aim to continue making programmatic investment decisions with the goal of building an integrated, seamless, and outcome-oriented behavioral health system that utilizes a health equity lens to ensure critical services are available to those in need.

BHS priorities and achievements to highlight, include:

- Supporting service providers as they **transition to a new normal in the wake of the pandemic**, to ensure the continuity of service delivery to our most vulnerable clients.
- Continuing our **pursuit of the Triple Aim**: 1) to improve the health of populations, 2) to enhance the patient experience and outcomes of individuals, and 3) to reduce per capita costs of care. This includes establishing redesigning outpatient mental health services to ensure better patient outcomes.
- Continuing to **enhance data integration, and advance diversity and health equity work** by enhancing data sciences and population health capacities within BHS, and partnering with the University of California at San Diego (UCSD), to develop the Community Experience Project (CEP) with the purpose of identifying and addressing unmet behavioral health needs within the region, and the systemic and regional inequities.
- Continuing the transformation of the behavioral health continuum and **addressing the urgent behavioral health needs of our communities** through the expansion of crisis services such as Mobile Crisis Response Teams (MCRTs) and new crisis stabilization units (CSUs).
- Focusing on **investments that yield immediate high impacts and improve client engagement**, including enhancements to diversionary services designed to keep people out of acute care and connected to ongoing services, inpatient and long-term care, and care coordination services.

As we continue on this journey, we will continue to strengthen collaboration with partners, stakeholders, consumers, and other community members to improve the health of our region to ensure all residents are able to live well and thrive.

Sincerely,

Luke Bergmann, Ph.D., Director
Behavioral Health Services, County of San Diego Health and Human Services Agency

MHSA OVERVIEW

BACKGROUND

The Mental Health Services Act (MHSA) was passed by California voters in November 2004 and became law on January 1, 2005. The MHSA imposes a one-percent income tax on personal annual income in excess of $1 million. The vision of the MHSA is to build a system in which mental health services are more accessible and effective, utilization of out-of-home and institutional care is reduced, and stigma toward those with serious mental illness (SMI) or serious emotional disturbance (SED) is eliminated.

The MHSA provides critical resources to help our most vulnerable populations by supporting County of San Diego (County) mental health programs and monitors progress toward statewide goals for children, transition-age youth (TAY), adults, older adults, and families. MHSA funding supports programs to help with prevention and early intervention needs, along with infrastructure, technology, and training to effectively support the public mental health system. Counties also have the opportunity to implement innovative programs to test new mental health treatments. After more than a decade of consistent growth and expansion, the County must turn its emphasis to improving processes and focus on the most effective approaches demonstrated by successful outcomes.

In the County, a majority of MHSA services are provided by community-based service providers, including non-profits, a majority of which are awarded through competitively procured contracts. Our service providers are connected to the community; therefore, are able to understand the immediate needs of our clients. To ensure quality services are provided, teams of subject-matter experts within the County's Health and Human Services Agency, Behavioral Health Services (BHS) department oversee programs through regular contract monitoring and communication with service providers. MHSA programs are client-centered, culturally aware, and employ detailed outcome measures that include clinical and functional improvement or stabilization, progress toward client goals, and achievement of client satisfaction.

As required by the Welfare and Institutions Code, counties must complete a three-year plan and subsequent annual updates for MHSA-funded programs. The most recent MHSA Three-Year Plan for Fiscal Years (FY) 2020-21 through 2022-23 provided program and expenditure information for the five MHSA components: Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), Workforce Education and Training (WET), and Capital Facilities and Technological Needs (CFTN). This Annual Update provides an overview of the recent Community Planning Process (CPP), summarizes outcomes for FY 2019-20, and outlines adjustments to the three-year plan in FYs 2021-22 and 2022-23.

INVESTMENTS

The proposed MHSA spending plan for FY 2021-22 is $218.6 million as outlined in the chart below, reflecting an increase of $23.2 million from the original MHSA Three-Year Plan budget for FY 2021-22. By the end of FY 2021-22, it is estimated that the County will have invested nearly $2 billion in MHSA programs since its inception.

MHSA Component	*Three Year Plan FY 2021-22 Budget*	*Annual Update FY 2021-22 Budget*	*Variance*	*Percent of MHSA Budget*
Community Services and Supports (CSS)	$157,474,156	$179,462,347	$21,988,191	82%
Prevention and Early Intervention (PEI)	$26,323,724	$27,136,726	$813,002	12%
Innovation (INN)	$7,931,484	$8,351,643	$420,159	4%
Workforce Education and Training (WET)	$3,605,648	$3,605,648	$0	2%
Capital Facilities and Technological Needs (CFTN)	$0	$0	$0	0%
Total	**$195,335,012**	**$218,556,363**	**$23,221,351**	**100%**

The MHSA budget and program adjustments for FY 2021-22 are based on priorities identified during the CPP in conjunction with staff recommendations.

A summary of the proposed expenditures by each MHSA component for FY 2021-22 is available in Appendix A. Summaries of all programs funded with MHSA dollars are available in Appendix C.

LIVE WELL SAN DIEGO

Implementation of the MHSA demonstrates the County's commitment to the *Live Well San Diego* vision of achieving a healthy, safe, and thriving region. BHS is committed to providing accessible, community-based, and client-oriented services to all six Health and Human Services Agency (HHSA) service regions: North Coastal, North Inland, North Central, Central, East, and South. The MHSA enhances access to services, and encourages self-sufficiency, health, and well-being in children, adults, and families as demonstrated by the personal stories embedded throughout this report. By collaborating with individuals, community partners, local government, schools, and others, the County continues its goal of achieving healthy, safe, and thriving communities through collective impact. In FY 2019-20, MHSA-funded programs provided services to more than 71,000 children, youth and families, transition-age youth, adults, and older adults in the San Diego County, with an emphasis on individuals who were previously unserved or underserved.



ADVANCING DIVERSITY AND HEALTH EQUITY

The vision of the MHSA is to build a system in which mental health services are equitable, regionally distributed, and accessible to all individuals and families within the region who are in need. MHSA funding provides individuals who are experiencing SMI or SED with timely access to quality behavioral health care that is responsive to their cultural and linguistic needs. These programs serve individuals of all ages, providing support to the County's most vulnerable, unserved, and underserved populations.

The community need for behavioral health services continues to increase, especially amongst the most vulnerable populations and in the wake of the COVID-19 pandemic. To guide clinical service design and placement, and to ensure effective outcomes are achieved, BHS continues to enhance data integration and health equity work through the establishment of BHS Data Sciences and Population Health units. Additionally, BHS is partnering with the UCSD, to develop the Community Experience Project (CEP) with the purpose of identifying and addressing unmet behavioral health needs within the region, and the systemic and regional inequities that lead to these unmet needs.

The four objectives of the CEP include:

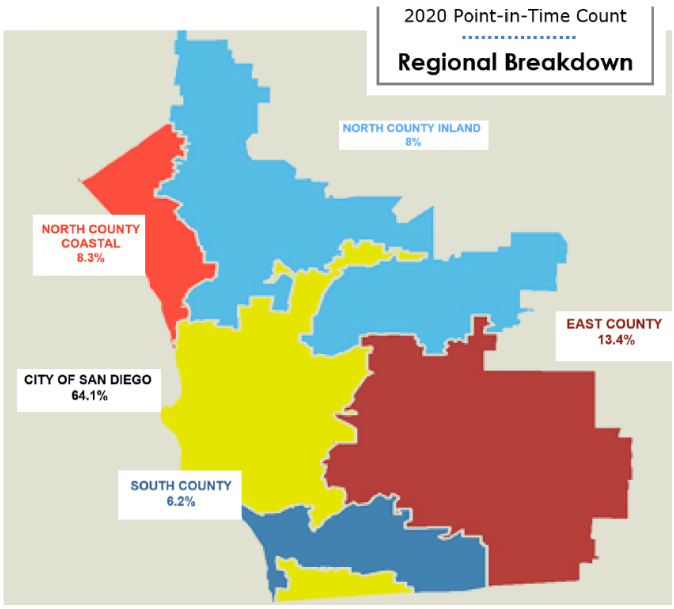
1. Creating a Behavioral Health Equity Index to highlight populations and neighborhoods at greatest risk for unmet behavioral health needs.
2. Developing an interactive Community Experience Dashboard that allows users to investigate behavioral health experiences by subpopulation (e.g., race/ethnicity, sexual orientation, etc.) and subregional area using timely community data sources.
3. Engaging community members and key stakeholders in the identification, collection, analysis, and interpretation of data and in the development of plans for action.
4. Developing brief, focused action reports to synthesize key findings and summarize priorities for intervention.

The final product will promote a continuous feedback process by which issues can be identified, further informed by community engagement, and mediated by actionable plans that will aid in informing the design of BHS programs, including services funded through MHSA.

A summary of programmatic and budgetary changes is available in the MHSA Accomplishment and Changes section of this report.

HOMELESSNESS AND HOUSING

Obtaining stable housing is critical in achieving health and wellness for individuals who are experiencing homelessness, or who are at risk of experiencing homelessness, and struggling with serious mental illness (SMI. In January 2020, more than 1,700 volunteers and outreach workers across San Diego County participated in the 2020 Point-in-Time Count, an annual effort to identify the number of persons experiencing homelessness in San Diego County. According to the 2020 WeAllCount Report[1], an estimated 7,638 (3,667 sheltered and 3,971 unsheltered) men, women, and children identified as experiencing homeless in San Diego County. Of those, 12 percent were veterans, 20 percent were



[1] 2020 WeAllCount Report: https://www.rtfhsd.org/wp-content/uploads/2020-WeAllCount-Report-10.pdf

chronically homeless, 7 percent were unsheltered youth, and 5 percent were families. MHSA programs continue to provide extensive outreach, engagement, treatment services, and permanent supportive housing to individuals with SMI who are experiencing homelessness. The map above outlines the homeless population, by region, identified in the 2020 WeAllCount Report.

PROJECT ONE FOR ALL (POFA)

In February 2016, the San Diego County Board of Supervisors implemented Project One for All (POFA) with a goal of connecting 1,250 individuals with SMI who are experiencing homelessness to housing and behavioral health services. POFA provides adults with SMI who are experiencing homelessness with fully integrated services, including outreach, case management, mental health treatment services, substance use disorder (SUD) services, referrals to primary health care, social services, and housing to ensure stability and live their best life. As of January 2021, 1,793 individuals experiencing homelessness were housed and received BHS services through POFA.

LOCAL GOVERNMENT SPECIAL NEEDS HOUSING PROGRAM (SNHP)

The County has dedicated more than $53 million of MHSA CSS funds to the California Housing Finance Agency (CalHFA) for the Local Government Special Needs Housing Program (SNHP) and its predecessor, the MHSA Housing Program. Upon completion, these programs will result in approximately 377 permanent supportive housing units. Of the 377 units, 329 units have been operationalized, 25 units are scheduled to begin leasing by fall 2021, and 23 units are planned for development.

Status of Housing Units	# of Housing Units
Operationalized	329
Scheduled to be Leased	25
Planned for Development	23
Total Housing Units	**377**

NO PLACE LIKE HOME (NPLH)

On July 1, 2016, Governor Brown signed the NPLH Act (SB 1206) into legislation. This program dedicates $2 billion in bond proceeds to invest in the development of permanent supportive housing for persons with SMI who are experiencing homelessness or are at risk of experiencing homelessness. NPLH funds may be used to finance capital costs of rent-assisted units in rental housing developments, including costs associated with acquisition, design, construction, rehabilitation, or preservation. The bonds will be repaid with funds reallocated from MHSA funds.

On July 17, 2017, the State of California, Department of Housing and Community Development issued the final program guidelines for the NPLH program. According to the guidelines, the County is eligible to receive a total of approximately $125 million, resulting in an annual estimated MHSA revenue reduction of $11 million. Counties eligible to receive NPLH funding must commit to provide mental health services and help coordinate access to other community-based supportive services. On November 6, 2018, Proposition 2, the ballot initiative to implement the NPLH Act of 2018 was approved by voters through a statewide general election. In FY 2018-19, MHSA funds were allocated to fund County staff dedicated to support the implementation and administration of the NPLH program. Beginning in FY 2019-20, funding for debt service is excluded from MHSA revenue received by the counties. As of April 2021, there are six developments, totaling 172 NPLH units, with conditional NPLH funding and services commitments.

COLLABORATION WITH JUSTICE, COURTS, AND PROBATION

Many MHSA programs provide access and support for individuals either entering or exiting juvenile detention, jails, or courts. Programs collaborate with the courts, the San Diego County Sheriff's Department, the County Probation Department, and other law enforcement agencies to support successful reintegration of clients into the community through prompt and appropriate identification and treatment of behavioral health issues. The goal is to place people into the appropriate level of treatment and reduce recidivism. In FY 2021-22, the total estimated investment in justice-related MHSA programs will be $36 million.

See Appendix D for a list of MHSA programs that serve justice-involved clients.

THE JOURNEY AHEAD

The COVID-19 pandemic greatly impacted the delivery of behavioral health services within the community; however, BHS continued to make forward progression in shifting how residents of San Diego County access care and support for behavioral health needs. In Fiscal Year 2021-22, the County infused additional financial, staffing, and other resources into behavioral health services, which are more critical than ever post pandemic.

Though the MHSA revenue outlook appears to be better than expected in the wake of the pandemic, the County continues to mitigate the volatility of MHSA revenue projections by utilizing short, mid, and long-term strategies to ensure the continuity of critical service delivery to our most vulnerable populations, as follows:

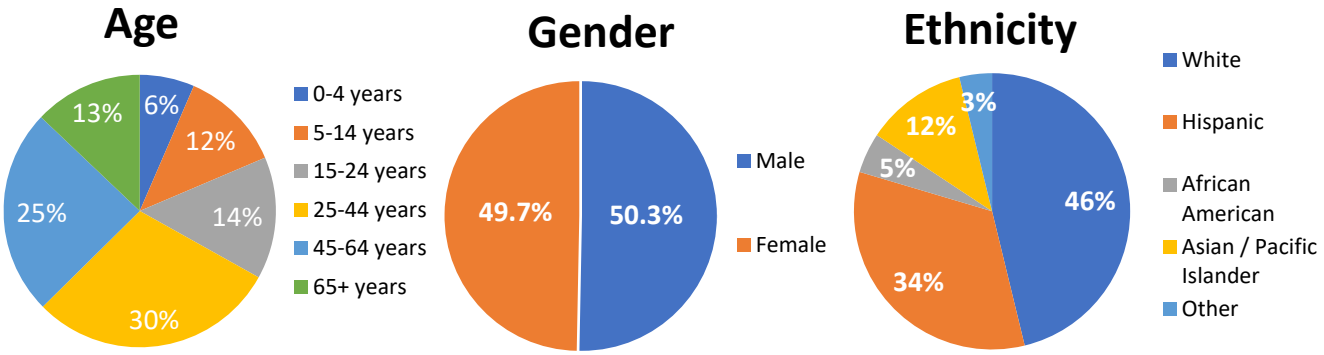
- Continuing to reflect enhanced Medi-Cal drawdown in FY 2021-22 (FMAP) in the MHSA Annual Update Expenditure Plan
- Continuing to optimize and maximize Medi-Cal drawdown within BHS programs
- Continuing to conduct intensive evaluations of all BHS programs to ensure service delivery optimization, maximum efficiency, effective outcomes, and alignment with the Behavioral Health Continuum of Care
- Continuing support for flexibility to use funds between components, primarily CSS and PEI, outside of the prescribed percentage allocations to ensure continuity of critical services (excluding INN funds) **CSAC Memo, AB 81 (Chapter 13, Statutes of 2020)**
- Continuing advocacy for the flexibility in use of unspent INN funds, including:
    - Using INN funds for CSS and PEI components, to ensure the continuity of essential services
    - Authorizing counties to expend funds for their innovative programs without approval by the Mental Health Services Oversight and Accountability Commission (MHSOAC) if the program is establishing or expanding a program implementing the full-service partnership model of service

DEMOGRAPHICS

San Diego County, California is located near the Pacific Ocean in the far southwestern part of the United States, has nearly 70 miles of coastline, and shares an 80-mile international border with Mexico. It is among the nation's most geographically varied regions with urban, suburban, and rural communities throughout coastal, mountain, and desert environments. According to the U.S. Census Bureau, San Diego County has an area of 4,526 square miles, of which 4,207 square miles are land and 319 square miles are water. San Diego County's estimated population for 2020 was 3,302,833[2], making it the second-most populous county in California and the fifth-most populous county in the United States.

The culturally diverse region boasts robust technology and health industries, a business-friendly climate, green practices, and a high quality of life. It is home to world-class educational institutions and a large military presence. Over 223,000 veterans are estimated to reside in the region along with additional active military personnel and their families.

The estimated demographics for San Diego County based on 2014-2018 U.S. Census data from the American Community Survey 5-year estimates:



The region is expected to further diversify with a steady increase in the Hispanic population. The two most widely spoken languages at home are English and Spanish, with nearly 45 percent of county residents being bilingual. The county's threshold languages continue to be Spanish, Vietnamese, Arabic, Tagalog, and Farsi.

Additional demographic data for San Diego County is located in Appendix E.

[2] Based on U.S. Census Bureau estimated population estimate as of December 10, 2020

COMMUNITY PROGRAM PLANNING (CPP) PROCESS

The Community Program Planning (CPP) process provides stakeholders with the opportunity to identify priorities, provide feedback and make recommendations on how MHSA funds will be best invested to best meet the needs of county residents. Throughout the year, BHS engages in open dialogue with the Behavioral Health Advisory Board (BHAB), System of Care Councils, various stakeholders and stakeholder-led councils, organizations, and individuals in various settings to determine priorities, solicit feedback and make recommendations for the utilization of MHSA funds. Additionally, on an annual basis as required by Welfare and Institutions Code, BHS facilitates formal behavioral health community engagement sessions that are open for the public, to inform the MHSA Three Year Plan and subsequent Annual Updates.

In 2020, the objective of the community engagement forums was to gather the community's perspective on the value of BHS programs with a focus on the impact of the pandemic on behavioral health. Through a contract with the Institute for Public Health (IPH) at San Diego State University, BHS conducted all community engagement events virtually in compliance with the physical distancing guidelines put forth by the Public Health Orders. The primary finding of this year's formal community engagement process, primarily attributed to the circumstances of the pandemic, reflected the public's recognition of an ongoing and potentially worsening behavioral health crisis. Two virtual community listening sessions – one designed for behavioral health care providers and the other for youth and families – were held. In addition, 11 focus groups were hosted that prioritized communities of identity and/or geography. Finally, 10 one-on-one phone interviews were conducted.

Participants in this year's engagement forums were asked to describe behavioral health trends they were observing within the community, with a specific focus on the impact of the pandemic. They were asked to share ideas about topics BHS should prioritize along with strategies to strengthen resiliency within the community. Findings resulting from the engagement sessions consistently demonstrated a concern that an increasing number of people were suffering from anxiety, depression, and substance use disorders, with some cohorts of populations suffering disproportionately with behavioral health conditions. Forum participants completed a satisfaction survey to evaluate the value of the engagement. Event attendance totaled 201, including 158 participants in the community listening sessions, 33 participants in the focus groups, and interviews with 10 people. Participants were actively involved in the events and expressed a high degree of satisfaction with the engagement process.

BHS collaborated with local and State public safety and justice system stakeholders, along with the Department of State Hospitals, to strengthen partnerships, develop strategies, and leverage funding for programs. These programs strive to divert clients with SMI or SED and who may be experiencing homelessness from justice system involvement and link them with appropriate behavioral health services within our system of care. Examples of these diversion efforts can be seen in our Behavioral Health Court, our continued Psychiatric Emergency Response Team (PERT) programs and the recent implementation of the MCRTs. Custody "in-reach" programs and services have also been developed and expanded to assist clients in successfully transitioning from custody back into the community and decrease recidivism. Finally, collaborative efforts continue with California Department of Correction and Rehabilitation (CDCR) to assist clients leaving State prisons who are re-entering in the community and need behavioral health services.

The FY 2020-21 Community Engagement Report can be found in Appendix F.

MHSA ANNUAL UPDATE REVIEW AND PUBLIC COMMENT PERIOD

A draft of the FY 2021-22 MHSA Annual Update was posted on the BHS website and the Clerk of the Board of Supervisors website on August 3, 2021. The plan was sent to BHS stakeholders, including the San Diego Mental Health Coalition, Mental Health Contractors Association, and hospital partners.

The County's BHAB comprised of consumers, family members, prevention specialists, and professionals from the mental health and substance use disorder fields who represent each of the five County Supervisorial districts, held a public hearing at the conclusion of the 30-day public review and comment period.

Stakeholder comments on the FY 2021-22 MHSA Annual Update are available in Appendix Q. The MHSA Issue Resolution Process for filing and resolving stakeholder concerns related to the MHSA CPP, and ensuring consistency between program implementation and approved plans, is available in Appendix G.

MHSA ACCOMPLISHMENTS AND CHANGES

The section below summarizes programmatic accomplishments in FY 2019-20, and budgetary changes from the MHSA Three-Year Plan for programs in FYs 2020-21 and 2021-22. Changes are outlined for each of the five MHSA components, including Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), Workforce Education and Training (WET), and Capital Facilities and Technological Needs (CFTN).

A detailed budget by component can be found in Appendix A.

COMMUNITY SERVICES AND SUPPORTS (CSS)

CSS provides comprehensive services for children, youth, families, adults, and older adults experiencing SMI or SED. CSS programs enhance the mental health system of care resulting in the highest benefit to the client, family, and community, with a focus on unserved and underserved populations. In FY 2021-22, the estimated total budget for CSS programs is $179.5 million, reflecting a total increase of $22.0 million from the MHSA Three-Year Plan funding priorities for FY 2021-22.

Up to $3.6 million of CSS funds annually will be transferred to the Workforce Education and Training (WET) component to continue funding programs identified in the WET section of this report.

Full-Service Partnership (FSP) programs advance goals to reduce institutionalization and incarceration, reduce homelessness, and provide timely access to help by providing intensive wraparound treatment, rehabilitation, and case management. The FSP program philosophy is to do "whatever it takes" to help individuals achieve their goals, including recovery. Services provided may include, but are not limited to, mental health treatment, linkage to medical care, and life-skills training. Funds can also be used to fund permanent supportive housing or housing supports.

As required by the California Code of Regulations (CCR), Title 9, Division 1, Chapter 14, Article 6, Section 3620 (c), each county "*shall direct the majority of its Community Services and Supports funds to the Full-Service Partnership Service Category.*" FSP programs account for a majority of the MHSA CSS budget in FY 2021-22.

Outreach and Engagement (OE) programs target unserved and underserved populations to reduce health disparities. Culturally competent services include peer-to-peer outreach, screening of children and youth, and school and primary care-based outreach to children and youth. Programs collaborate with community-based organizations, mental health and primary care partnerships, faith-based agencies, tribal organizations and health clinics, and organizations that help individuals who are experiencing homelessness or who are incarcerated. Outreach services link potential clients to services.

System Development (SD) programs improve existing services and supports for individuals who currently receive services. This includes peer support (e.g., wellness centers), education, advocacy, and mobile crisis teams. SD programs aim to improve the public mental health system by promoting interagency and community collaboration and services, and developing the capacity to provide values-driven, evidence-informed clinical practices.

A detailed budget for CSS can be found in Appendix A and the CSS Annual report is available in Appendix H. A summary of the estimated cost per client is available at the end of the CSS section.

CSS PROGRAMS FOR CHILDREN, YOUTH, AND FAMILIES



CSS programs for children, youth, and families (CYF) serve children and adolescents through age 17 with SED and their families, including TAY ages 16-21. CYF offers a wide variety of services, from early intervention to residential services, aiming to meet the unique linguistic and cultural needs of San Diego County residents.

Children's FSP programs include school-based outpatient services, walk-in assessments, mobile assessment teams, medication support, intensive mental health services, case management, referrals and linkages, and assessments and interventions for people with co-occurring disorders.

The FSP FY 2019-20 outcome report for children and adolescents is available in Appendix I.

CHILDREN, YOUTH, AND FAMILIES – FULL-SERVICE PARTNERSHIPS (CY-FSP)

In FY 2021-22, the estimated total MHSA budget for CY-FSP programs is $22,105,367. In FY 2021-22, the estimated annual cost per unduplicated client served in CY-FSP programs is $6,279, inclusive of all funding, and the estimated number of unduplicated clients to be served is 9,734.

HIGHLIGHTS FROM FY 2019-20:

CHILDREN'S SCHOOL-BASED FULL-SERVICE PARTNERSHIP (FSP) (CY-FSP)

School-based FSP programs provide culturally competent outpatient services at easily accessible locations throughout the county, including clinics, schools, homes, and the community. Services include individual therapy, family therapy, case management, rehabilitation support, and medication management to children, youth, and their families. The services are client- and family-driven, and are provided by specialized teams of staff, including family partners who are employees with lived experience. Services offered are trauma-informed and recognize that a whole-person approach is critical to promote overall wellbeing. Partnership with the family, primary care, and education is a primary focus of successful treatment. In FY 2019-20, 26 school-based FSP the programs served 7,851 unduplicated clients.

In FY 2019-20, as schools switched to remote learning in response to the COVID-19 pandemic, the programs transitioned to offer telehealth and remote services. In FY 2018-19, CYF launched SchooLink to Behavioral Health Services (SchooLink), a web-based resource. The purpose of SchooLink is to implement standardized practices to increase collaboration between schools and providers of mental health and SUD treatment programs, and to provide system-level data that was previously unavailable. Resources are able to be optimally deployed by tracking and reviewing data on service utilization throughout the school system.

FAMILY THERAPY (CY-FSP)

The family therapy participation engagement program is a component of selected outpatient mental health clinics which uses parent partners with lived experience to provide education and support to caregivers of children and youth with SED. The program educates caregivers on the benefits of being actively engaged in the treatment process and works collaboratively with the family to address and resolve barriers to participation. In FY 2019-20, six family therapy programs served 768 unique clients.

ENHANCEMENTS AND CHANGES FOR FYS 2020-21 AND 2021-22:

CHILDREN'S SCHOOL-BASED FULL-SERVICE PARTNERSHIP (FSP) (CY-FSP)

School-based FSP programs provide culturally competent outpatient services at easily accessible locations throughout the county, including clinics, schools, homes, and the community. Services include individual therapy, family therapy, case management, rehabilitation support, and medication management to children, youth, and their families. In FY 2021-22, the MHSA budget increased by $6,510,911 to meet the needs of students returning to class after a year of distance learning and disruption. This initial investment increases access, quality and effectiveness of school-based mental health services through expanded on-campus hours and increased individualized services to students through lower clinician caseloads. Services will address social determinants of health, and include increased collaboration with the school districts and families to improve mental health and wellness alongside attendance, academic performance, and social connectedness. Funding will be equitably distributed to facilitate access to services to youth from historically underserved communities.

CHILDREN, YOUTH AND FAMILIES - OUTREACH AND ENGAGEMENT (CY-OE)

In FY 2021-22, the estimated total MHSA budget for CY-OE programs is $1,599,163; the estimated cost per unduplicated client served in CY-OE programs is $594, inclusive of all funding; and the estimated number of unduplicated clients to be served is 2,690.

HIGHLIGHTS FROM FY 2019-20:

PARENT PARTNER SERVICES (CY-OE)

The Parent Partner Services program provides supportive behavioral health services to residents in the Southeastern region of San Diego County which includes case management, support and education groups, community resource fairs, and focus groups to learn about the community needs. This program also provides linkage to behavioral health treatment and education services. By providing linkage to services, the program can prevent clients from entering higher levels of care by engaging youth and their families before mental health issues arise. In FY 2019-20, the program provided outreach and engagement services to 126 families.

ENHANCEMENTS AND CHANGES FOR FYS 2020-21 AND 2021-22:

There are no budgetary changes to report.

CHILDREN, YOUTH AND FAMILIES - SYSTEM DEVELOPMENT (CY-SD)

In FY 2021-22, the estimated total MHSA budget for CY-SD programs is $11,978,536; the estimated cost per unduplicated client served in CY-SD programs is $4,575, inclusive of all funding; and the estimated number of unduplicated clients to be served is 4,428.

HIGHLIGHTS FROM FY 2019-20:

BHS CHILDREN, YOUTH AND FAMILIES (CYF) LIAISON (CY-SD)

The CYF Liaison program collaborates with BHS administrative staff to ensure the needs of its enrolled children, youth, and their families are incorporated into service development, implementation planning, and service delivery. The liaison interacts with the community via trainings, meetings, and cloud-based applications to provide information on behavioral health services available in San Diego County while also providing CYF administration with information collected about the behavioral health needs of the community. The contract was amended in January 2019 to include the addition of cloud-based trainings. In FY 2019-20, a total of 401 individuals participated in 22 cloud-based trainings.

CRISIS ACTION AND CONNECTION (CAC) (CY-SD)

The Crisis Action and Connection program provides children and youth who have had a recent acute psychiatric episode with intensive support and linkage to services and community resources. This program improves access to, and benefits of, mental health services to children, youth, and their families, which helps to divert or prevent the use of acute services. The overall program was strengthened through two MHSA components known as Rapid Response and Intensive Respite. Rapid Response partners with the PERT to expedite deployment of clinicians to support the youth and avoid escalation. Intensive Respite supports the mental health needs of youth who are in a short-term respite setting. In FY 2019-20, the program served 457 unduplicated clients.

PEER MENTORING (CY-SD)

The San Pasqual Academy (SPA) program provides individual, group, and family services to the County of San Diego Health and Human Services Agency, Child Welfare Services (CWS) youth in placement. Services include individual, group and family treatment, care coordination, case management, rehabilitative services, medication services, and peer mentorship to promote growth towards independence and self-sufficiency as youth transition to adulthood. Through the peer mentoring program, alumni who have successfully transitioned from SPA provide support to current students by modeling job skills, strong work ethic, and relationship skills. Peer mentors also provide awareness of independent living options, and information on how to facilitate growth toward independence and strengthen self-confidence. In FY 2019-20, 63 unique mentees participated in the program.

ENHANCEMENTS AND CHANGES FOR FYS 2020-21 AND 2021-22:

There are no budgetary changes to report.

CSS Programs for Transition Age Youth, Adults, and Older Adults



CSS programs for TAY (age 18-25), adults (age 26-59), and older adults (age 60+) (TAOA) provide services to individuals with SMI, SED, or co-occurring disorders, and their families. Programs provide integrated, recovery-oriented mental health treatment services, outreach and engagement, case management and linkage to other services, and vocational support.

FSP assertive community treatment (ACT) programs use a "whatever it takes" model to comprehensively address individual and family needs and focus on resilience and recovery to help individuals achieve their mental health treatment goals. Adult FSP programs provide: ACT services, supported housing (temporary, transitional, and permanent), intensive case management, wraparound services, community-based outpatient services, rehabilitation, and recovery services, supported employment and education services, dual-diagnosis services, peer support, justice system transition support, and other services.

The FSP/ACT outcome report for TAY, adults and older adults is available in Appendix J. The Fiscal Year FY 2019-20 Update to the Five-Year BHS Housing Plan is available in Appendix K. Details of the housing projects funded through MHSA CSS funds can be found here: https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/mental_health_services_act/mhsa_housing.html

TAY, Adults and Older Adults – Full-Service Partnerships (TAOA-FSP)

In FY 2021-22, the estimated total MHSA budget for TAOA-FSP programs is $49,173,977, with estimated cost per unduplicated client served in TAOA-FSP programs at $11,110 for TAY and adults, and $9,840 for older adults, inclusive of all funding. The estimated number of unduplicated clients to be served is 5,708 and 874, respectively.

Highlights from FY 2019-20:

Full-Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from Acute (TAOA-FSP)

The FSP/ACT step down from acute program provides ACT services to clients with SMI who are homeless or at risk of homelessness and who are stepping down from acute care. These clients are not connected to outpatient services and are being discharged from an acute care facility back into the community. The step-down program increases clinical and functional stability through a variety of mental health services, housing opportunities and educational and employment supports. The ACT program also provides Strength-Based Case Management (SBCM) services to clients who are not able to transition to a stand-alone SBCM program. In FY 2019-20, the program served 66 clients stepping down from behavioral health hospitals.

Full-Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from Institutions of Mental Disease (IMD) (TAOA-FSP)

The FSP/ACT step down from IMD program provides ACT services to clients with SMI who are homeless or at risk of homelessness and stepping down from a long-term care facility such as a skilled nursing facility, state hospital or IMD. These clients are not connected to outpatient services and are being discharged from a long-

term care facility back into the community. The step-down program increases clinical and functional stability through a variety of mental health services, housing opportunities and educational and employment supports. The program also provides SBCM services to clients who are not able to transition to a stand-alone SBCM program. In FY 2019-20, the program served 45 clients stepping down from long term care facilities.

ENHANCEMENTS AND CHANGES FOR FYS 2020-21 AND 2021-22:

ADULT RESIDENTIAL TREATMENT (TAOA-FSP)

The adult residential treatment program provides a broad range of services in a residential environment to assist individuals improve their quality of life and work towards independent living. These services include physical health screening and referrals to primary care professionals, wellness groups, peer support services, mentoring, and employment and education assistance. In FY 2020-21, the budget increased by $289,445 to provide four additional beds to the long-term system of care.

FULL-SERVICE PARTNERSHIP (FSP) / ASSERTIVE COMMUNITY TREATMENT (ACT) (TAOA-FSP)

FSP/ACT programs provide intensive community-based services for persons who are homeless or at risk of homelessness, are experiencing SMI, and who may have a co-occurring substance use disorder to achieve success and independence. These programs employ a "whatever it takes" model to help clients avoid the need for emergency services such as crisis stabilization, crisis outpatient, crisis residential, and services provided at the psychiatric hospital. ACT teams provide medication management, mental health services, vocational services, substance abuse services, and other services to help clients sustain the highest level of functioning while remaining in the community. In FY 2021-22, the budget increased by $900,000 due to increased capacity that resulted in the ability to serve an additional 50 clients annually.

FULL-SERVICE PARTNERSHIP (FSP) / ASSERTIVE COMMUNITY TREATMENT (ACT) – HOUSING (TAOA-FSP)

FSP/ACT housing programs provide housing and supports to persons experiencing SMI who are homelessness or at-risk of homelessness. Programs offer an array of short-term, transitional, and permanent supportive-housing resources, including housing subsidies provided through partnerships with local housing authorities. Homeless-dedicated ACT programs have MHSA housing funds for rental and non-rental housing assistance, as well as dedicated housing staff such as housing coordinators and housing specialists to provide housing navigation and ongoing tenancy support services. In FY 2021-22, the budget increased by $150,000 to support a portion of housing needs for the approximately 50 additional ACT treatment slots annually.

STRENGTHS BASED CASE MANAGEMENT (SBCM) (TAOA-FSP)

The SBCM programs provide case management services along with physical health referrals, peer counseling, linkage to services, and access to resources for persons who have SMI. In FY 2021-22, the budget increased by $634,500 to serve approximately 75 additional clients annually, and to enhance capacity related to treatment and housing.

COUNTY OF SAN DIEGO - PROBATION (TAOA-FSP)

The Probation Department provides a Probation Officer for FSP/ACT programs through behavioral health court. The staff provides interventions, case management, and supervision of juveniles and adults who are at risk of entering the justice system or re-offending while placed on probation by the courts. In FY 2021-22, the budget decreased by $316,690 due to funding reallocation associated with two embedded ACT Probation Officers.

TAY, ADULTS AND OLDER ADULTS OUTREACH AND ENGAGEMENT (TAOA-OE)

In FY 2021-22, the estimated total MHSA budget for TAOA-OE programs is $752,112; the estimated cost per unduplicated client served in TAOA-OE programs is $499, inclusive of all funding; and the estimated number of unduplicated clients to be served is 2,500.

HIGHLIGHTS FROM FY 2019-20:

NON-RESIDENTIAL SUBSTANCE USE DISORDER (SUD) TREATMENT & RECOVERY SERVICES – ADULT (TAOA-OE)

Non-residential SUD treatment and recovery centers provide services to adults with co-occurring disorders, to achieve recovery through screenings and linkage to services. These services include treatment groups, care coordination, and crisis counseling, which can reduce justice system involvement and use of emergency medical services. These programs assist individuals to become and remain free of SUD problems addressing both disorders for adults experiencing co-occurring SUD and mental health problems.

In FY 2019-2020, the East Regional Recovery Center, one of the SUD treatment and recovery centers, provided 27,949 alcohol and drug treatment and recovery services to a total of 1,244 unduplicated clients. In FY 20-21, the program implemented a new Library Social Worker program located in the El Cajon County Library. This program has been very successful by expanding and updating resources, and by providing linkage to members of the community.

ENHANCEMENTS AND CHANGES FOR FYS 2020-21 AND 2021-22:

There are no budgetary changes to report.

TAY, ADULTS AND OLDER ADULTS – SYSTEM DEVELOPMENT (TAOA-SD)

In FY 2021-22, the estimated total MHSA budget for TAOA-SD programs is $59,220,491; the estimated cost per unduplicated client served in TAOA-SD programs is $2,395, inclusive of all funding; and the estimated number of unduplicated clients to be served is 46,758.

HIGHLIGHTS FROM FY 2019-20:

BIO-PSYCHOSOCIAL REHABILITATION (BPSR) (TAOA-SD)

BPSR recovery centers provide a wide variety of outpatient mental health services such as rehabilitation medication management, care coordination, recovery services, and employment support at multiple locations throughout the county. The program offers specific program services dedicated to TAY and older adult geriatric specialists who provide culturally and age-appropriate services. These programs help improve an individual's level of functioning, quality of life, and housing status, as well as linkage to services, obtaining employment, and linkage to primary care services.

NEW LEAF RECOVERY CENTER
A PERSONAL STORY

A client at New Leaf Recovery Center (NLRC) struggled with finding employment, and eventually caught COVID-19, which was another barrier towards finding employment. An Employment Specialist continued to work (through telehealth) with this client to find employment, and the client was eventually able to find part time work, which will help him sustain his housing and remain in treatment at NLRC.

In FY 2019-20, New Leaf, one of the BPSR recovery centers, served 394 unduplicated clients, exceeding the annual projection of 370. Standardized measures are used to determine an individual's functional and clinical

improvement. Functional improvement refers to how well an individual operates and interacts in their environment including relationships with others, employment, education, etc. Clinical improvement is focused on the symptoms an individual may be experiencing including psychosis, hallucinations, periods of depression, etc. The program outcome measure for functional improvement of 90 percent exceeded the annual projection of 75 percent. The outcome measure for clinical improvement of 85.4 percent exceeded the annual projection of 75 percent.

CRISIS STABILIZATION UNIT (CSU) - NORTH INLAND (TAOA-SD)

The North Inland CSU at Palomar Health provides critical treatment services in a hospital-based setting adjacent to the emergency or urgent care unit at Palomar Hospital in Escondido for individuals experiencing a psychiatric crisis to stabilize and connect them to ongoing services that meet their individual needs. The CSU provides 24-hour services to vulnerable patients in a safe setting under the direct and constant supervision of behavioral health staff to reduce risk of a psychiatric hospitalization. Patients have access to emergency department services if medical crises arise. In FY 2019-20, the program served 1,235 unduplicated clients; a monthly average of 85 percent of clients were diverted from admission to an inpatient Behavioral Health Unit. Additionally, 88 percent were not readmitted to the CSU within 30 days of discharge.

ENHANCEMENTS AND CHANGES FOR FYS 2020-21 AND 2021-22:

AUGMENTED SERVICES PROGRAM (ASP) (TAOA-SD)

ASPs provide additional services to individuals with SMI in licensed residential care facilities, also referred to as board and care facilities, to help them maintain or improve functioning in the community and to prevent or minimize institutionalization. In FY 2021-22, the budget increased by $4,624,520 primarily due to enhanced capacity. This increased funding will result in 100 additional ASP beds as well as fund associated recruitment costs for identifying an additional 125 ASP beds.

BIO-PSYCHOSOCIAL REHABILITATION (BPSR) (TAOA-SD)

BPSR recovery centers provide a wide variety of outpatient mental health services such as rehabilitation medication management, care coordination, recovery services, and employment support at multiple locations throughout the county. The program offers specific program services dedicated to TAY and older adult geriatric specialists who provide culturally and age-appropriate services. In FY 2021-22, the budget increased by $10,000,000 as a result of a BPSR mental health outpatient programs redesign to enhance walk-in capacity, increase total clients served, provide community-based services, reduce client to staff ratios, and increase care coordination.

CRISIS STABILIZATION UNIT (CSU) – SOUTH (TAOA-SD)

The CSU South Region provides critical treatment services in a hospital-based setting for individuals experiencing a psychiatric crisis to stabilize and connect them to ongoing services that meet their individual needs. The CSU provides 24-hour services to vulnerable patients in a safe setting under the direct and constant supervision of behavioral health staff to reduce risk of a psychiatric hospitalization. Patients have access to emergency department services if medical crises arise. In FY 2021-22, the budget increased by $1,661,857 to align with the annual contract budget.

CRISIS STABILIZATION UNIT (CSU) – NORTH COASTAL OCEANSIDE (TAOA-SD)

The CSU North Coastal Oceanside is a 24-hour community-based CSU located at the North Coastal Live Well Health Center that will provide critical care services in a non-hospital setting for individuals experiencing a psychiatric crisis to stabilize and connect them with ongoing services that meet their individual needs. In

addition, the CSU will be co-located with the North Coastal Mental Health Clinic, the Mariposa Clubhouse, and the McAlister North Coastal Regional Recovery Center allowing the facilitation of a warm handoff to ongoing outpatient services when appropriate. Services are expected to begin in the fall of 2021. In FY 2021-22, the budget for this program increased by $5,700,000.

CRISIS STABILIZATION UNIT (CSU) – NORTH COASTAL VISTA (TAOA-SD)

The CSU North Coastal Vista is a 24-hour community-based CSU that will provide critical care services in a non-hospital setting for individuals experiencing a psychiatric crisis to stabilize and connect them with ongoing services that meet their individual needs. Services will be in close proximity to the walk-in assessment center in Vista, detailed below, which provides mobile mental health crisis response and intervention services. In FY 2021-22, the budget for this program increased by $5,361,864.

WALK-IN ASSESSMENT CLINIC AND MOBILE ASSESSMENT TEAM (CY-SD)

The Walk-In Assessment Clinic and Mobile Assessment Team provides mobile mental health crisis response and intervention services, as well as walk-in assessment clinics for the North County. The program reduces the use of emergency and inpatient services, prevents escalation, and promotes the management of mental illness. In FY 2021-22, the program budget decreased of $3,338,593 due to the transfer of funds to the CSU North Coastal Vista program referenced above.

CSS Programs for All Ages (ALL)

CSS programs for all ages serve families and individuals of all ages and offer a variety of outreach, engagement, and outpatient mental health services with individualized, family-driven services and supports. Clients are linked to appropriate agencies for medication management and services for co-occurring substance use disorders. Various services are provided for specific populations and communities, including victims of trauma and torture, Chaldean and Middle Eastern communities, and individuals who are deaf or hard of hearing.



ALL AGES - OUTREACH AND ENGAGEMENT PROGRAMS (ALL-OE)

In FY 2021-22, the estimated total MHSA budget for ALL-OE programs is $3,028,446; the estimated cost per unduplicated client served in ALL-OE programs is $1,130, inclusive of all funding; and the estimated number of unduplicated clients to be served is 2,759.

HIGHLIGHTS FROM FY 2019-20:

Behavioral Health Services - Victims of Trauma and Torture (ALL-OE)

This program improves access to mental health services for victims of trauma and torture who are experiencing or at risk of SMI or SED and are at risk of developing new or worsening behavioral symptoms. Through culturally specific outreach and education, the program goal is to increase access to, and use of, mental health services, outreach, and education to the specific population. In FY 2019-20, the program served 80 unique clients. In FY 20-21, 80 percent of clients whose episode lasted six months or longer showed clinical improvement or stabilization over the previous six-month period.

Behavioral Health Services for Deaf & Hard of Hearing (ALL-OE)

This program provides outpatient mental health services, case management, and integrated SUD treatment and rehabilitation services tailored to individuals with SMI who are deaf and/or hard of hearing to achieve a more adaptive level of functioning. The program includes group or individual sessions, crisis intervention, and referrals to other community-based organizations. In FY 2019-20, the program served 61 unique clients.

In March 2020, when a shelter in place order was established due to the COVID-19 pandemic, the program focused efforts on educating clients on the public health orders due to cultural and linguistic barriers faced by the population. The program was able to transition all therapeutic, case management, and medication management services online quickly to ensure access to clients.

Clubhouse - Deaf or Hard of Hearing (ALL-OE)

This member-operated clubhouse provides social skill development and rehabilitative, recovery, vocational, and peer support services for individuals who are experiencing SMI and are deaf or hard of hearing. In FY 2019-20, the program served 83 unduplicated clients.

In March and April 2020, many members of the Clubhouse required education on the severity of the COVID-19 pandemic and safety measures due to cultural and linguistic barriers. The program staff created videos (vlogs) and visual materials to educate and communicate with their members in a more effective manner.

BEHAVIORAL HEALTH SERVICES AND PRIMARY CARE INTEGRATION SERVICES (ALL-OE)

The BHS and Primary Care Integration Services program facilitates the integration of care by providing evidence-based treatment of behavioral health interventions to individuals in primary care settings. A short-term, solution-focused treatment model is used to provide mental health services to primary care clients at multiple Federal Qualified Health Center sites throughout the county. In addition, a peer promotora program provides outreach to adults and older adults by linking them to mental health services at health centers as well as support groups. In FY 19-20, the program served 889 unduplicated clients.

In June 2019, the program received the 2019 Behavioral Health Services Director's Program of the Year Award from the County of San Diego for their work in supporting clients and family members with achieving recovery without stigma. The program was highlighted for providing integrated, comprehensive, and holistic health care within a single treatment facility through an innovative, effective, client-friendly, and cost-effective model.

ENHANCEMENTS AND CHANGES FOR FYS 2020-21 AND 2021-22:

There are no budgetary changes to report.

ALL AGES - SYSTEM DEVELOPMENT (ALL-SD)

In FY 2021-22, the estimated total MHSA budget for ALL-SD programs is $8,196,124; the estimated cost per unduplicated client served in ALL-SD programs is $1,187, inclusive of all funding; and the estimated number of unduplicated clients to be served is 10,344.

HIGHLIGHTS FROM FY 2019-20:

CHALDEAN AND MIDDLE EASTERN SOCIAL SERVICES (ALL-SD)

The Chaldean and Middle Eastern Social Services (CMSS) program provides culturally competent mental health services, including outpatient clinics, case management, and linkages to services for individuals of Middle Eastern descent who are experiencing SMI or SED. Children and youth with SED have access to outpatient clinical services and may be connected to acculturation groups. In FY 2019-20, the program served 197 unique clients. During to the COVID-19 pandemic, the clinic adapted its practices to remain open and continue to serve clients. In FY 20-21, CMSS provided nearly 80 percent of all psychotherapy and medication support services via telehealth.

PSYCHIATRIC EMERGENCY RESPONSE TEAM (PERT) (ALL-SD)

The PERT program partners clinicians with specially trained police officers and deputies to ensure a more effective intervention and response to support individuals who are experiencing a mental health crisis while interacting with law enforcement. PERT teams are on-call and can be deployed countywide to provide

PSYCHIATRIC EMERGENCY RESPONSE TEAM
A PERSONAL STORY

PERT responded to a call for service on a young woman who was expressing danger to self in the community. PERT staff interviewed the young woman and learned that she was involved in an arranged marriage and had an extensive history of trauma and abuse. The PERT clinician further explored the situation and learned the woman was trying to leave the abusive situation and relocate to be near her family. The PERT clinician provided several resources and was able to connect the woman with resources. A few months later, PERT received a letter from the woman who had successfully relocated, was living independently, and was scheduled for a job interview.

de-escalation support. In FY 2019-20, PERT provided a total of 34,743 contacts, including 12,263 crisis intervention contacts and 22,480 community contacts. Of the 12,263 crisis intervention contacts, 5,826 (48 percent) were diverted from hospitalization.

ENHANCEMENTS AND CHANGES FOR FYS 2020-21 AND 2021-22:

MOBILE CRISIS RESPONSE TEAM (MCRT) (ALL-SD)

The MCRT is a field-based program utilizing teams that consist of a clinician, case manager, and a peer, that respond to emergency (non-911) calls to provide crisis intervention for individuals in a behavioral health crisis, and to connect them to the most appropriate level of care. This new program became operational in FY 2020-21 and will continue to grow resulting in a total budget increase of approximately $2,000,000. In the short period the program has been operational, it has exceeded the goal to divert at least 80 percent of clients from higher level services.

CSS PROPOSED EXPENDITURE PLAN AND ESTIMATED COST PER CLIENT

The table below represents the estimated cost per client for FY 2021-22, including all revenue sources. MHSA, Realignment, Federal Financial Participation (FFP) and other revenue sources are represented in the proposed budget since they are comingled within services.

MHSA CSS Work Plan	Population Served	FY 2021-22 Proposed Budget (All Funding)	FY 2021-22 Estimated Number of Unduplicated Clients	FY 2021-22 Estimated Cost Per Client
CY-FSP	Children, Youth	$61,116,675	9,734	$6,279
CY-OE	Children, Youth	$1,599,163	2,690	$594
CY-SD	Children, Youth	$20,256,887	4,428	$4,575
TAOA-FSP	Adults, TAY	$63,414,768	5,708	$11,110
TAOA-FSP	OA	$8,568,550	874	$9,804
TAOA-OE	TAY, Adults, OA	$1,246,272	2,500	$499
TAOA-SD	TAY, Adults, OA	$111,970,454	46,758	$2,395
ALL-OE	ALL	$3,116,434	2,759	$1,130
ALL-SD	ALL	$12,277,718	10,344	$1,187
Total CSS		**$283,566,920**	**85,795**	

Assumptions:

- Figures are rounded to the nearest whole number and therefore may not exactly add up to the total.
- The proposed funding and cost per client estimates are inclusive of all direct funding within the programs, including MHSA, Realignment, Federal Financial Participation (FFP) and other funding.
- Administrative costs are not included.
- The FY 2021-22 estimated cost per client figures are based on the total proposed FY 2020-21 budget divided by the actual clients served in FY 2019-20, plus the estimated new unduplicated clients to be served in FY 2021-22. FY 2019-20 data is the most recent full year of data available.
- The estimated average cost per client is a summary by work plan. The figure will vary by level of care and contract due to the varying contracted rates, services provided, and number of duplicate clients.
- The annual projected unique clients for FY 2021-22 will vary from the number of unique clients served in Appendix H, I and J because some programs no longer exist, and new programs will be added in FY 2021-22. Additionally, clients may receive one or more different services, so there may be duplication of clients across work plans.

PREVENTION AND EARLY INTERVENTION (PEI)

Prevention and Early Intervention (PEI) programs bring mental health awareness to members of the community through public education initiatives and dialogue. To ensure access to appropriate support at the earliest point of emerging mental health symptoms, PEI builds capacity for providing mental health early intervention services at sites where people go for other routine activities. Through PEI, mental health becomes part of wellness for individuals and the community, reducing the potential for stigma and discrimination against individuals with mental illness.



In FY 2021-22, the estimated total budget for PEI programs is $27,136,726. As required by MHSA, a majority of funding for PEI programs must be directed to programs that serve persons less than 25 years of age. In FY 2021-22, this requirement will be met with nearly 60 percent of the budget for PEI programs budgeted for programs serving persons less than 25 years of age.

A detailed budget for PEI may be found in Appendix A. The FY 2019-20 PEI system-wide summary report can be found in Appendix L.

A summary of the estimated cost per client is available at the end of the PEI section.

HIGHLIGHTS FROM FY 2019-20:

POSITIVE PARENTING PROGRAM (TRIPLE P) (EC-01)

The Positive Parenting Program is a training class which strengthens skills for parents with children in Head Start, Early Head Start and elementary school settings, who are exhibiting behavioral and/or emotional challenges. Families requiring specialty mental health services are linked directly to services and remain connected after completing the program and have the opportunity for individual consultations for up to six months. Through education and training, the program reduces child abuse, mental illness, behavioral and emotional problems, delinquency, and school failure. In FY 2019-20, the program served 20,152 unique clients. 95 percent of parents reported that the program has helped them deal more effectively with their children's behavior.

POSITIVE PARENTING PROGRAM
A PERSONAL STORY

A stay-at-home mother of two children, suffered from post-partum depression after the birth of each of her children. She wanted a resource to help her feel more confident with her parenting skills and was recommended to the Positive Parenting Program offered by Jewish Family Services of San Diego. After completing the online program, she stated that she felt better equipped to handle the stresses of child rearing and is also seeing improvements in her children's behavior. "[The children] are more responsive when I use some of the tools and there's less resistance when I'm asking them to do something," she said.

ELDER MULTICULTURAL ACCESS & SUPPORT SERVICES (EMASS) (OA-01)

EMASS convenes promotores, members of the community who are leaders in social circles and who are experienced working with people experiencing SMI in underserved communities, including Filipino, Latino, African refugee, African American, and Middle Eastern. These promotores are trained by professionals to

provide outreach and engagement to older adults, and engage them in group and individual activities, including recreation, exercise, mental health education, and counseling to prevent mental illness. EMASS also provides referrals to multilingual mental health providers, transportation services, and translation services during medical and mental health appointments. In FY 2019-20, the program served 1,541 unique clients. 91 percent of participants rated the program as satisfactory or highly satisfactory on the Early Intervention Satisfaction Survey.

As part of California's Master Plan for Aging, EMASS was chosen this spring to represent San Diego County in the "Ensuring Equity in Aging" webinar series produced by the California Department on Aging. In cooperation with the Office of Refugee Resettlement, EMASS provides services for more than 50 refugees in East San Diego County, using its Community Health Worker model to engage older adults in Farsi-speaking communities.

HOME-BASED SERVICES - FOR OLDER ADULTS (POSITIVE SOLUTIONS) (OA-02)

Positive Solutions provides home-based outreach, prevention and intervention services to older adults who are homebound and socially isolated. The program reaches out to these adults and engages them with the Program to Encourage Active and Rewarding Lives which is an evidence-based program that provides mental health screening, assessment, counseling, and referral and linkage to care. In FY 2019-20, the program served 4,946 unique clients. 86 percent of the clients reported reduced symptoms of depression after program completion.

COUNTY OF SAN DIEGO - COMMUNITY HEALTH PROMOTION SPECIALISTS (PS-01)

Community Health Promotion Specialists (CHPS) staff within the HHSA Regions and Aging & Independence Services (AIS), in partnership with BHS staff, serve as community ambassadors for behavioral health prevention and early intervention initiatives. The CHPS staff develop and provide community outreach materials and conduct prevention activities to support events and awareness campaigns, including May is Mental Health Awareness Month, Suicide Prevention Month, Recovery Happens, and Check Your Mood.

FAMILY PEER SUPPORT PROGRAM (PS-01)

The Family and Adult Peer Support programs, Friends in the Lobby and In Our Own Voice, provide outreach and awareness through training and the dissemination of education materials in primary care, senior centers, faith-based forums, and other venues. Individuals with lived experience promote social and emotional wellness for adults, older-adults, and their families who are visiting individuals that have been hospitalized in psychiatric units. The programs reduce stigma and discrimination, increase acceptance of mental illness and awareness of treatment choices, and increase access and use of available services, especially in unserved and underserved communities. Volunteers engage individuals, offer support, and answer questions in hospital lobbies throughout the county. In FY 2019-20, the program served 4,224 unique clients. 100 percent of presentation attendees reported that they believe that recovery for a mental health condition as possible.

MENTAL HEALTH FIRST AID (PS-01)

The Mental Health First Aid (MHFA) program provides individuals the skills to help someone who is developing a mental health problem or experiencing a mental health crisis. The program provides countywide, community-based education and training services. In FY 2019-20, the program trained 6,596 unique community members. 100 percent of MHFA adult course attendees successfully complete the course as documented by the MHFA Opinion Quiz.

SUICIDE PREVENTION & STIGMA REDUCTION MEDIA CAMPAIGN - IT'S UP TO US (PS-01)

The countywide media campaign, It's Up to Us, focuses on suicide prevention, stigma reduction, and increased public awareness around behavioral health. The campaign provides awareness of the stigma of mental illness, promotes individual acceptance of mental illness, and provides materials and information on options for intervention, treatment, and recovery. In FY 2019-20, the campaign included over 3,005 television spots, 1,566 radio spots, 117 out of home placement billboards and transportation advertisements, and 406 social media posts reaching most of San Diego County's 3.2 million residents. All media channels yielded an exposure to the brand and messages of over 133 million impressions.

SUICIDE PREVENTION ACTION PLAN (PS-01)

The San Diego Suicide Prevention Council establishes the Suicide Prevention Action Plan to increase public awareness, increase understanding of suicide risks and warning signs, and reduce stigma and harmful outcomes. The plan has a special focus to reach some of the most vulnerable communities such as LBGTQ, TAY, veterans, and older adults. The program's goal is to increase the number of individuals who are trained to recognize and prevent the immediate risk of suicide. A copy of the plan can be found at: https://www.sdchip.org/wp-content/uploads/2020/09/FINAL_SPC-Report-to-the-Community-2020.pdf. In FY 2019-20, the program trained 2,660 individuals. The suicide rate in 2019 decreased by 7.9 percent, from 13.9 to 12.8 per 100,000 population, the lowest rate since 2011.

SCHOOL-BASED SUICIDE PREVENTION & EARLY INTERVENTION (HERE NOW) (SA-02)

The Helping, Engaging, Reconnecting and Educating (HERE) Now program provides school-based suicide prevention education and intervention services to middle-school students, high-school students, and TAY. Presentations on bullying, depression, and warning signs of suicide are provided to students, teachers, staff, and parents to increase awareness, promote conversations, and inspire connections. In FY 2019-20, the program served 34,349 unique clients. Schools were closed for on-site instruction starting in March 2020, due to COVID-19 guidance, and remained closed for in person learning through spring 2021. The program pivoted to a virtual platform and provided trainings when permissible. 90 percent of students and 80 percent of staff attended trainings.

VETERANS & FAMILY OUTREACH EDUCATION (COURAGE TO CALL) (VF-01)

The Courage to Call program provides confidential outreach, education, peer counseling, referrals, and support services to veterans and their families to increase awareness of mental illness and reduce mental-health risk factors. The program increases awareness of mental illness in the veteran community through these efforts to reduce mental-health risk factors. Services are provided to veterans and their family members. In FY 2019-20, the program served 1,334 adults and to 1,611 families. After the declaration of the COVID-19 pandemic, Courage to Call was able to pivot to a hybrid service model resulting in 67 percent successful linkages to referrals for needed services.

CAREGIVER SUPPORT FOR ALZHEIMER'S & DEMENTIA PATIENTS (OA-06)

The Caregiver Support for Alzheimer's and Dementia Patients program provides education, training, and early intervention to prevent or decrease symptoms of depression and other mental health issues among caregivers of people suffering from Alzheimer's and another dementia. The program raises awareness of the mental health needs of caregivers and encourages them to access County-funded prevention and early intervention services to improve wellness. In FY 2019-20, the program provided 75,405 individuals with mental health prevention education and awareness information and enrolled 322 individuals in the six-week caregiver education curriculum-based component. There were 276 individuals who received post caregiver education support and 96 individuals were assessed for the prevalence of clinical depression and other mental issues and received brief intervention services or were referred for longer-term care as needed.

BREAKING DOWN BARRIERS (BDB) INITIATIVE (PS-01)

Breaking Down Barriers is an outreach campaign that engages individuals in underserved communities including Latino, African American, Native American, African immigrants/refugees, and LGBTQ to increase access to mental health services. The program reduces stigma and discrimination through increased awareness and acceptance of mental illness and treatment choices and increases access and use of available services. In FY 2019-20, the program served 4,067 individuals attending workshops and presentations, both in-person and virtual sessions, with 85 percent of post-session participants demonstrating an increased knowledge of mental health stigma and knowledge of the factors leading to mental health stigma.

ENHANCEMENTS AND CHANGES FOR FYS 2020-21 AND 2021-22:

INTEGRATED PEER & FAMILY ENGAGEMENT (CO-03)

The Integrated Peer and Family Engagement program provides comprehensive, peer-based care coordination, mental health screening, brief treatment, and system navigation to adults with SMI and SUD. The peer and family support program focuses on whole-person health, self-management, self-care skills, and linkage to treatment and community resources. In FY 2020-21, the budget increased by $417,110 for additional SUD counselors to assist with referrals to the appropriate SUD level of care for treatment.

PEI Proposed Expenditure Plan and Estimated Cost Per Client

The table below represents the estimated cost per client for FY 2021-22, including all revenue sources. MHSA, Realignment, Federal Financial Participation (FFP) and other revenue sources are represented in the proposed budget since they are comingled within services.

MHSA PEI Work Plan	Population Served	FY 2021-22 Proposed Budget (All Funding)	FY 2021-22 Estimated Number of Unduplicated Clients	FY 2021-22 Estimated Cost Per Client
CO-03 Integrated Peer & Family Engagement	ALL	$2,942,490	5,052	$582
DV-03 Alliance for Community Empowerment	Children, Youth	$403,520	306	$1,319
DV-04 Community Services for Families - Child Welfare Services	Children, Youth	$504,408	458	$1,101
EC-01 Positive Parenting Program (Triple P)	Children, Youth	$1,109,680	7,614	$146
FB-01 Early Intervention for Prevention of Psychosis (Kick Start)	Children, TAY	$1,790,620	450	$3,979
NA-01 Native American Prevention and Early Intervention (Dream Weaver)	ALL	$1,760,356	6,196	$284
OA-01 Elder Multicultural Access & Support Services (EMASS)	OA	$574,162	1,541	$373
OA-02 Home Based Services - For Older Adults (Positive Solutions)	OA	$583,652	4,946	$118
OA-06 Caregiver Support for Alzheimer & Dementia Patients	Adults, OA	$1,090,271	75,000	$15
PS-01 Education and Support Lines	ALL	$4,781,900	17,691	$270
RC-01 Rural Integrated Behavioral Health and Primary Care Services	ALL	$1,407,276	910	$1,546
RE-01 Independent Living Association (ILA)	TAY, Adults, OA	$302,640	-	-
SA-01 School Based Prevention and Early Intervention	Children, Youth	$6,355,440	11,440	$556
SA-02 School Based Suicide Prevention & Early Intervention (Here Now)	Children, Youth, TAY	$1,815,840	34,349	$53
VF-01 Veterans & Family Outreach Education (Courage to Call)	ALL	$1,291,264	2,945	$438
Total PEI		**$26,713,518**	**168,898**	

Assumptions:

- Figures are rounded to the nearest whole number and therefore may not exactly add up to the total.
- The proposed funding and cost per client estimates are inclusive of all direct funding within the programs. Figures may include MHSA, Realignment, Federal Financial Participation (FFP), and other funding. Administrative costs are not included.
- The following program does not have client count data:
  - RE-01: Independent Living Association
- The FY 2021-22 estimated cost per client figures are based on the total proposed FY 2021-22 budget divided by the actual number of clients served in FY 2019-20, plus the estimated new clients to be served in 2021-22. FY 2019-20 is the most recent full year of data available.
- The estimated average cost per client is a summary by work plan. The figure will vary by service and contract based on the contracted rate, level of care, and number of duplicate clients.
- The annual projected unique clients for FY 2021-22 will vary from the number of unique clients served in Appendix L.

INNOVATION (INN)

Innovation projects are short-term, novel, creative mental health practices or approaches that contribute to learning. INN programs require data analysis and evaluation services to assess client and system outcome measures. INN programs have evaluation funds embedded within the total program budget - allocated to evaluation services provided by the UCSD.



In FY 2021-22, the estimated INN expenditures will be $8,351,643.

A detailed budget for INN may be found in Appendix A. The Innovation Report can be found in Appendix N.

A summary of the estimated cost per client is available at the end of this INN section.

HIGHLIGHTS FROM FY 2019-20:

ROAM Mobile Services (INN-20)

Roaming Outpatient Access Mobile Services (ROAM) are mobile clinics that provides culturally appropriate mental health services to individuals living in rural areas. This program increases access to, and usage of, mental health services by providing services via mobile clinics on tribal lands to individuals that may be difficult to engage due to their lack of available services in the area. In FY 2019-20, ROAM enrolled a total of 242 participants and provided nearly 1,900 behavioral health related services.

Due to the COVID-19 pandemic, the ROAM program accelerated the planned adoption of telehealth and telepsychiatry services via phone and video sessions. ROAM teams reported generally favorable experiences using technology to engage with and provide behavioral health services to participants. With the transition to telehealth services, ROAM program staff reported a decrease in “no-shows” for scheduled appointments and an increase in client willingness to participate in program services.

Medication Clinic (INN-22)

The Medication Clinic program provides ongoing medication management to children and youth who have successfully completed mental health treatment, and who have medication needs that are too complex for their primary care physician to manage. In FY 2019-20, the clinic provided on-going stabilization for approximately 383 children and youth with complex psychiatric medication needs.

ENHANCEMENTS AND CHANGES FOR FYS 2020-21 AND 2021-22:

Recuperative Services Treatment (ReST) - Recuperative Housing (INN-21)

The ReST program engages TAY who are discharged from acute emergency mental health care and are experiencing homelessness or at risk of experiencing homelessness. The goal is to prevent future emergency care by providing short-term (up to 90 days) comprehensive, on-site services to link clients to permanent housing, ongoing mental health services, and other needed resources. In FY 2020-21, the budget increased by $331,729 to align with the annual contract budget.

INN ESTIMATED COST PER CLIENT

The table below represents the estimated cost per client for FY 2021-22, including all revenue sources. MHSA, Realignment, Federal Financial Participation (FFP) and other revenue sources are represented in the proposed budget since they are comingled within services.

MHSA INN Work Plan	Population Served	FY 2021-22 Proposed Budget (All Funding)	FY 2021-22 Estimated Number of Unduplicated Clients	FY 2021-22 Estimated Cost Per Client
INN-18 Peripartum Program	TAY, Adults	$1,072,858	300	$3,576
INN-19 Telemental Health	ALL	$1,132,972	250	$4,532
INN-20 ROAM Mobile Services	ALL	$1,896,840	200	$9,484
INN-21 ReST Recuperative Housing	TAY (ages 18-25)	$1,408,676	54	$26,087
INN-22 Medication Clinic	Children, Youth	$1,990,820	510	$3,904
INN-24 Early Psychosis Evaluation and Learning Health Care Network	Youth, TAY	$201,626	245	$823
Total		**$7,703,792**	**1,559**	

Assumptions:

- Figures are rounded up to the nearest whole number and therefore may not exactly add up to the total.
- The proposed funding and cost per client estimates are inclusive of all direct funding within the programs. Figures may include MHSA, Realignment, Federal Financial Participation (FFP) and other funding. Administrative costs are not included.
- The FY 2021-22, estimated cost per client figures are based on the total proposed FY 2021-22 budget divided by the estimated proposed number of clients to be served in FY 2021-22, based on estimates from the programs.
- The estimated average cost per client is a summary by work plan.

WORKFORCE EDUCATION AND TRAINING (WET)

WET programs provide support, education, and training to the public mental health workforce to address the shortage of qualified individuals who provide services to persons with SMI or SED in the county. The WET component of MHSA provides training and financial incentives to increase the public behavioral health workforce, and it improves the competency and diversity of the workforce to better meet the needs of the population receiving services.



In FY 2021-22, the estimated WET expenditures will be $3,605,648.

Annually, up to $3.6 million in CSS funds will be transferred to the WET component to continue funding programs. WET funds were received as a one-time allocation and the balance of WET funds has been fully expended; therefore, the need for additional WET funds will be evaluated annually.

A detailed budget for WET may be found in Appendix A.

HIGHLIGHTS FROM FY 2019-20:

CONSUMER & FAMILY ACADEMY (WET-03)

The Consumer & Family Academy provides training support to individuals with lived experience that work in, or plan to work in, the public behavioral health system. The academy provides standardized training certifications for individuals working in public behavioral health programs. In FY 2019-20, 65 participants graduated from the program. By the end of the training series, 29 of the graduates were employed within the public behavioral health system. Due to the COVID-19 pandemic, peer employment training education for BHS provider staff shifted from in-person classes to virtual meetings. 98 individuals received training and education on peer employment training components and supervisory skills for peer supervisors.

PUBLIC MENTAL HEALTH ACADEMY (WET-03)

The Public Mental Health Academy (PMHA) prepares students for local employment opportunities in entry-level public behavioral health systems. The PMHA provides academic counseling and support for students interested in pursuing a career in public behavioral health. It was created to address the shortage and lack of diversity in public mental health service providers. The program provides a career pathway in public behavioral health by offering coursework leading to a Mental Health Work Certificate of Achievement. During the 2019-20 academic year, 62 students were enrolled in the program and 42 students completed the program, which brings the total to 312 total graduates since the program's inception. Over 355 academic counseling appointments were held to provide individuals on-going support and guidance.

PUBLIC MENTAL HEALTH ACADEMY
A PERSONAL STORY

My experience with the Mental Health Certificate program was far beyond my expectations. The classes and materials presented were extremely helpful and useful to real world situations I will encounter in the mental health field. All my professors were knowledgeable professionals and helped all of us students understand the subject at hand and provided needed assistance whenever necessary. They created an atmosphere of trust and this enabled us to relax, ask questions and learn in a completely stress-free environment.

ENHANCEMENTS AND CHANGES FOR FYS 2020-21 AND 2021-22:

There are no budgetary changes to report.

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)



Capital Facilities and Technological Needs (CFTN) funding is used for capital projects and technological capacity to improve mental illness service delivery to clients and their families. Capital Facilities funds may be used to acquire, develop, or renovate buildings, or to purchase land in anticipation of constructing a building. Expenditures must result in a capital asset, which permanently increases the San Diego County infrastructure. Technological Needs funds may be used to increase client and family engagement by providing the tools for secure client and family access to health information. The programs modernize information systems to ensure quality of care, operational efficiency, and cost effectiveness.

CFTN funds were received as a one-time allocation that were fully spent in FY 2019-20.

MHSA DATA COLLECTION AND ANALYSIS

In order to determine if services are meeting expected outcome measures, BHS collects, analyzes, and reports MHSA data in monthly, quarterly, and annual reports prepared by the BHS Quality Improvement (QI) team. The BHS Performance Improvement Team also monitors targeted aspects of care and service provision on an on-going basis. Data is analyzed over time to determine whether program outcomes are being met and to inform decision making. Additionally, BHS regularly shares data reports during the CPP process and at various points throughout the year and seeks guidance on further enhancing and refining data collection. To enhance the validity of the data, BHS partners with research organizations to collect, analyze, and report on extensive data that tracks activity, measures outcomes, and describes the populations being reached.

OPTUM SAN DIEGO

Optum San Diego (Optum) serves as the Administrative Services Organization for BHS, facilitating the County's role in administering certain inpatient and outpatient Medi-Cal and realignment-funded specialty mental health services. Optum also conducts ongoing quality review of therapy treatment plans and evaluation reports prepared for CWS cases, and evaluation reports prepared for Juvenile Probation cases. Additionally, it operates a 24-hour Access and Crisis Line (ACL) for callers to access and navigate the behavioral health system of care. The ACL provides referrals and information for mental health, SUD and other services, and access to emergency mental health services.

CHILD AND ADOLESCENT SERVICES RESEARCH CENTER

The Child and Adolescent Services Research Center (CASRC) is a consortium of more than 100 investigators and staff from multiple research organizations in San Diego County and Southern California, including Rady Children's Hospital, UCSD, San Diego State University, University of San Diego, and University of Southern California. The mission of CASRC is to improve publicly-funded mental health service delivery and quality of treatment for children and youth who have—or are at risk of SED.

HEALTH SERVICES RESEARCH CENTER

The Health Services Research Center (HSRC) is a non-profit research organization located within the Department of Family and Preventive Medicine at UCSD. The HSRC research team specializes in the measurement, collection, and analysis of health outcomes data to help improve healthcare delivery systems and, ultimately, improve client quality of life.

HSRC works in collaboration with the BHS QI team to evaluate and improve behavioral health outcomes for county residents. Aspects of the outcomes and service demographics are referenced throughout this MHSA Annual Update, and full reports are attached in Appendices H, I, J, and L.

APPENDICES

APPENDIX A

MHSA EXPENDITURE PLAN

Appendix A
FY 2021-22 Annual Update Mental Health Services Act Expenditure Plan
Funding Summary

County: San Diego

	A	B	C	D	E	F	G	
	Community Services and Supports	**Prevention and Early Intervention**	**Innovation**	**Workforce Education and Training**	**Capital Facilities and Technological Needs**	**Prudent Reserve**	**Totals**	**Comments**
A. Estimated FY 2021/22 Funding								
1. Estimated Unspent Funds from Prior Fiscal Years	$ 40,867,089	$ 16,714,136	$ 24,736,597	$ 2,151,070	$ -	$ 33,478,186	$ 117,947,078	
2. Estimated New FY2021/22 Funding*	$ 161,867,991	$ 40,466,998	$ 10,649,210	$ -	$ -	$ -	$ 212,984,198	Estimated revenue + interest
3. Transfers in FY2021/22[a/]	$ (3,600,000)	$ -	$ -	$ 3,600,000	$ -	$ -	$ -	
4. Access Local Prudent Reserve in FY2021/22							$ -	
5. Estimated Available Funding for FY2021/22	$ 199,135,080	$ 57,181,134	$ 35,385,807	$ 5,751,070	$ -	$ 33,478,186	$ 330,931,276	
B. Estimated FY2021/22 MHSA Expenditures	**$ 179,462,347**	**$ 27,136,726**	**$ 8,351,643**	**$ 3,605,648**	**$ -**		**$ 218,556,363**	
C. Estimated FY2021/22 Unspent Fund Balance	**$ 19,672,733**	**$ 30,044,408**	**$ 27,034,164**	**$ 2,145,422**	**$ -**	**$ 33,478,186**	**$ 112,374,913**	

* Estimated new funding from State consultant estimates in February 2021.

		Prudent Reserve Detail	
D. Estimated Local Prudent Reserve Balance	**Total**	*CSS*	*PEI*
1. Estimated Local Prudent Reserve Balance on June 30, 2021	$ 33,478,186	26,712,351	$ 6,765,835
2. Contributions to the Local Prudent Reserve in FY 2021/22	0	0	0
3. Distributions from the Local Prudent Reserve in FY 2021/22	0	0	0
4. Estimated Local Prudent Reserve Balance on June 30, 2022	$ 33,478,186	26,712,351	$ 6,765,835

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.

Assumptions
- Assumes enhanced Federal Financial Participation (FFP) Medi-Cal drawdown in FY2021-22 due to COVID-19. - Assumes optimization of FFP drawdown in FY 2021-22. - BHS will continue to support reallocation of unspent INN funds to CSS treatment programs due to COVID-19. - BHS will be conducting an departmental-wide analysis of programs to mitigate the MHSA revenue shortfall in future fiscal years by identifying efficiencies, optimizing Medi-Cal drawdown and analyzing program impacts and effectiveness in alignment with the Behavioral Continuum vision.

Appendix A
FY 2021-22 Annual Update Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

	Fiscal Year 2021/22					
	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						
CY-FSP Full Service Partnerships for Children & Youth						
Children's Full Service Partnership (FSP)	$ 1,008,800	849,686	159,114		-	
Children's School Based Full Service Partnership (FSP)	$ 47,262,467	14,990,492	27,650,723		4,621,252	
Family Therapy	$ 1,086,895	1,047,283	39,612		-	
Therapeutic Behavioral Services (TBS)	$ 4,907,812	2,434,402	2,473,410		-	
Wraparound Services (WRAP) - Child Welfare Services (CWS)	$ 6,850,700	2,783,504	2,174,750		1,892,446	
TAOA-FSP Full Service Partnerships for Ages 18-60+						
Adult Residential Treatment	$ 997,779	997,779	-		-	
Assisted Outpatient Treatment (AOT)	$ 1,441,696	1,010,762	430,934		-	
Behavioral Health Court	$ 1,892,509	1,253,782	638,727		-	
County of San Diego - Institutional Case Management (ICM)	$ 490,000	293,294	706		196,000	
County of San Diego - Probation	$ 585,000	224,324	-		360,676	
Crisis Residential Services - North Inland	$ 1,768,800	1,151,504	-		617,296	
Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	$ 43,318,468	23,925,220	17,172,004		2,221,244	
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	$ 11,847,517	11,757,517	90,000		-	
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from Acute	$ 2,030,706	2,030,706	-		-	
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from IMD	$ 2,127,623	2,127,623	-		-	
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	$ 2,774,200	2,664,200	-		110,000	
North Coastal Mental Health Center and Vista Clinic	$ 338,152	338,152				
Payee Case Management Services	$ 126,100	126,100	-		-	
Short-Term Mental Health Intensive Case Management - High Utilizers	$ 751,005	446,083	304,922		-	
Strengths Based Case Management (SBCM)	$ 1,493,763	826,931	666,832		-	
				-		
TOTAL Full Service Partnership (FSP) Programs	**$ 133,099,992**	**71,279,345**	**51,801,733**		**10,018,914**	**-**
Non-FSP Programs						
ALL-OE Outreach & Engagement for All Ages						
Behavioral Health Services - Victims of Trauma and Torture	$ 469,447	469,447	-		-	
Behavioral Health Services and Primary Care Integration Services	$ 1,025,167	1,025,167	-		-	
Behavioral Health Services for Deaf & Hard of Hearing	$ 368,212	280,223	87,989		-	
Clubhouse - Deaf or Hard of Hearing	$ 291,041	291,041	-		-	
Psychiatric and Addiction Consultation and Family Support Services	$ 962,568	962,568	-		-	
ALL-SD System Development for All Ages						
Chaldean and Middle-Eastern Social Services	$ 540,717	206,857	333,860		-	
EMT-MH Clinician Team	$ 259,262	259,262	-		-	
Psychiatric Emergency Response Team (PERT)	$ 9,460,140	5,712,405	-		3,747,735	
Mobile Crisis Response Team (MCRT)	$ 2,017,600	2,017,600				
CY-OE Outreach & Engagement for Children & Youth						
Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Women	$ 1,246,272	1,246,272				
Parent Partner Services	$ 352,890	352,890				
CY-SD System Development for Children & Youth						
Administrative Services Organization (ASO) - TERM	$ 356,776	356,776	-		-	
Adolescent Day Rehabilitation	$ 100,880	60,880	-		40,000	
BHS Children, Youth and Families (CYF) Liaison	$ 554,840	554,840	-		-	
BridgeWays Program	$ 564,928	247,077	93,851		224,000	
Commercially Sexually Exploited Children (CSEC)	$ 1,008,800	435,365	73,435		500,000	
County of San Diego - Juvenile Forensic Services	$ 1,100,000	1,100,000	-		-	
County of San Diego - Probation	$ -	-	-			
Crisis Action and Connection	$ 2,169,335	1,655,471	-		513,864	
Emergency Screening Unit (ESU)	$ 5,897,179	3,980,732	-		1,916,448	
Incredible Families	$ 1,961,329	898,920	270,723		791,686	
Incredible Years	$ 472,714	258,079	214,635		-	
Medication Support for Wards and Dependents	$ 854,454	353,261	162,392		338,800	
Mental Health Services - For Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ)	$ 1,513,200	812,392	100,808		600,000	
Peer Mentoring	$ 80,704	48,704	-		32,000	
Placement Stabilization Services	$ 2,257,737	384,427	1,873,309			
Rural Integrated Behavioral Health and Primary Care Services	$ 126,100	76,100	-		50,000	
Supplemental Security Income (SSI) Advocacy Services	$ 302,640	182,640	-		120,000	
Telemedicine	$ 21,300	21,300			-	

Appendix A
FY 2021-22 Annual Update Mental Health Services Act Expenditure Plan

Community Services and Supports (CSS) Component Worksheet

County: San Diego

Walk-In Assessment Clinic and Mobile Assessment Team	$ 913,973	551,573			362,400	
TAOA-OE Outreach & Engagement for Ages 18-60+						
Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Adult	$ 1,246,272	752,112	-		494,160	
TAOA-SD System Development for Ages 18-60+						
Augmented Services Program (ASP)	$ 7,253,922	7,253,922	-		-	
Behavioral Health Assessors	$ 691,028	387,028	-		304,000	
Bio-Psychosocial Rehabilitation (BPSR)	$ 33,052,310	7,880,269	17,808,774		7,363,267	
Client Liaison Services	$ 367,474	367,474	-		-	
Client Operated Peer Support Services	$ 754,986	754,986	-		-	
Clubhouse	$ 5,023,852	5,023,852	-		-	
Crisis Stabilization - North Coastal Oceanside	$ 5,750,160	2,216,160	3,534,000		-	
Crisis Stabilization - North Coastal Vista	$ 6,945,408	2,604,122	4,341,286		-	
Crisis Stabilization - North Inland	$ 10,245,258	4,190,083	4,821,033		1,234,142	
Crisis Stabilization - South	$ 7,628,401	5,160,378	1,030,351		1,437,672	
Faith Based Services	$ 1,487,446	1,487,446	-		-	
Family Mental Health Education and Support	$ 97,248	97,248	-		-	
Home Finder	$ 761,227	761,227	-		-	
In-Home Outreach Teams (IHOT)	$ 4,288,276	4,288,276	-		-	
Inpatient and Residential Advocacy Services	$ 572,221	572,221	-		-	
Institutional Case Mgmt (ICM) - Older Adults	$ 507,448	303,870	2,369		201,208	
Justice System Discharge Planning	$ 933,140	563,140	-		370,000	
Mental Health Advocacy Services	$ 442,748	442,748	-		-	
North Coastal Mental Health Center and Vista Clinic	$ 3,383,007	127,313	3,255,694		-	
North Inland Mental Health Center	$ 3,388,778	755,453	2,633,325		-	
NPLH BHS	$ 520,936	312,562	-		208,374	
NPLH Dept Pub Works Envir Svcs Unit	$ 27,500	5,500	-		22,000	
NPLH Housing & Community Dev Svcs	$ 1,199,155	500,661	-		698,494	
Peer Assisted Support Services	$ 904,955	904,955	-		-	
Public Defender - Behavioral Health Assessor	$ 240,000	144,000	-		96,000	
San Diego Employment Solutions	$ 1,127,637	680,517	-		447,120	
San Diego Housing Commission	$ 121,056	109,056	-		12,000	
Short Term Acute Residential Treatment (START)	$ 9,998,759	7,221,508	-		2,777,251	
Short-Term Bridge Housing	$ 1,203,332	1,203,332	-		-	
Supplemental Security Income (SSI) Advocacy Services	$ 504,400	504,400	-		-	
Telemedicine	$ 372,015	372,015	-		-	
Tenant Peer Support Services	$ 1,529,363	1,377,761	-		151,602	
Walk-In Assessment Center	$ 647,010	647,010			-	

Total Non-Full Service Partnership (FSP) Programs	**$ 150,466,928**	**$ 84,774,870**	**$ 40,637,834**	**$ -**	**$ 25,054,223**	**$ -**

CSS Administration	$ 23,408,132	$ 23,408,132				
CSS MHSA Housing Program Assigned Funds	$ -	$ -	$ -	$ -	$ -	$ -
Total CSS Program Estimated Expenditures	**$ 306,975,052**	**$ 179,462,347**	**$ 92,439,568**	**$ -**	**$ 35,073,138**	**$ -**
FSP Programs as Percent of Total	74.2%					

Appendix A
FY 2021-22 Annual Update Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: San Diego

	Fiscal Year 2021/22						
	A	B	C	D	E	F	
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding	PEI Category
PEI Programs							
1. CO-03 Integrated Peer & Family Engagement - Next Steps	$ 2,942,490	2,692,490			250,000		P
2. DV-03 Alliance for Community Empowerment	$ 403,520	403,520					P
3. DV-04 Point of Engagement	$ 504,408	504,408					P
4. EC-01 Positive Parenting Program	$ 1,109,680	669,680			440,000		P
5. FB-01 Kick Start	$ 1,790,620	417,774	662,846		710,000		EI
6. NA-01 Dream Weaver	$ 1,760,356	1,062,356			698,000		P
7. OA-01 Elder Multicultural Access & Support Services (EMASS)	$ 574,162	346,500			227,661		P
8. OA-02 Positive Solutions	$ 583,652	583,652					P
9. OA-06 Caregiver Support	$ 1,090,271	1,090,271					P
10. PS-01 Education and Support Lines							P / S&D / SP
Breaking Down Barriers (BDB) Initiative	$ 441,653	441,653					
County of San Diego - Community Health Promotion Specialists (	$ 620,703	372,422			248,281		
Family Peer Support Program	$ 200,307	200,307					
Mental Health First Aid	$ 504,400	504,400					
Suicide Prevention & Stigma Reduction Media Campaign - It's Up	$ 2,294,044	2,066,641			227,403		
Suicide Prevention Action Plan	$ 504,400	504,400					
Supported Employment Technical Consultant Services	$ 216,393	216,393					
11. RC-01 SmartCare	$ 1,407,276	1,407,276					P / EI
12. RE-01 Independent Living Association	$ 302,640	302,640					O
13. SA-01 School Based Program	$ 6,355,440	6,355,440					P
14. SA-02 Here Now	$ 1,815,840	1,815,840					SP
15. VF-01 Courage to Call	$ 1,291,264	1,291,264					A
PEI CATEGORIES:							
A - Access to Treatment							
EI - Early Intervention							
O - Outreach							
P - Prevention							
S&D - Stigma & Discrimination							
SP - Suicide Prevention							
Individual programs may serve more than one area							
PEI Administration	$ 3,487,399	$ 3,487,399					
PEI Assigned Funds	$ 400,000	$ 400,000					
Total PEI Program Estimated Expenditures	$ 30,600,917	$ 27,136,726	$ 662,846	$ -	$ 2,801,346	$ -	

Appendix A
FY 2021-22 Annual Update Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: San Diego

	Fiscal Year 2021/22					
	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 (Cycle 4)						
1. INN-18 Peripartum Services	$ 1,072,858	1,072,858				
2. INN-19 Telemental Health	$ 1,132,972	1,132,972				
3. INN-20 Roaming Outpatient Access Mobile (ROAM) Services	$ 1,896,840	1,896,840				
4. INN-21 Recuperative Services Treatment (ReST) Recuperative Housing	$ 1,408,676	1,408,676				
5. INN-22 Medication Clinic	$ 1,990,820	1,549,326	441,495			
6. INN-24 Early Psychosis and Learning Health Care Network	$ 201,626	201,626				
* Up to 5% for evaluation is embedded in Estimated INN Funding						
INN Administration	$ 1,089,345	$ 1,089,345				
Total INN Program Estimated Expenditures	$ 8,793,137	$ 8,351,643	$ 441,495	$ -	$ -	$ -

Appendix A
FY 2021-22 Annual Update Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: San Diego

	Fiscal Year 2021/22					
	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. WET-02 Training & Technical Assistance	$ 1,819,980	1,819,980				
2. WET-03 Mental Health Career Pathway Programs	$ 322,908	322,908				
3. WET-04 Residency and Internship Program	$ 1,462,760	1,462,760				
WET Administration	$ -	$ -	$ -	$ -	$ -	$ -
Total WET Program Estimated Expenditures	$ 3,605,648	$ 3,605,648	$ -	$ -	$ -	$ -

Appendix A
FY 2021-22 Annual Update Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: San Diego

	Fiscal Year 2021/22					
	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. CF-2 North County Mental Health Facility	$ -					
2. CF-4 North Inland Crisis Residential Facility	$ -					
3. CF-5 Emergency Screening Unit (ESU) Facility	$ -					
CFTN Programs - Technological Needs Projects						
1. SD-3 Personal Health Record	$ -					
2. SD-5 Telemedicine Expansion	$ -					
3. SD-6 MH MIS Expansion	$ -					
4. SD-8 Data Exchange	$ -					
5. SD-9 Financial Management System	$ -					
CFTN Administration	$ -	$ -				
Total CFTN Program Estimated Expenditures	$ -	$ -	$ -	$ -	$ -	$ -

APPENDIX B

CERTIFICATIONS AND MINUTE ORDER

Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: County of San Diego

☐ Three-Year Program and Expenditure Plan
☒ Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Luke Bergmann, Ph.D.	Name: Nadia Privara Brahms
Telephone Number: 619-563-2766	Telephone Number: 619-584-5036
E-mail: Luke.Bergmann@sdcounty.ca.gov	E-mail: Nadia.Privara@sdcounty.ca.gov
Local Mental Health Mailing Address: 3255 Camino Del Rio S, San Diego, CA 92108	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the 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 plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. *Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.*

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

Luke Bergmann, Ph.D.
Local Mental Health Director (PRINT)

Signature

10/15/21
Date

I hereby certify that for the fiscal year ended June 30, 2021, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 11/16/2020 for the fiscal year ended June 30, 2020. I further certify that for the fiscal year ended June 30, 2021, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local 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.

Brian Ruehle, Deputy Controller, Auditor & Controller
County Auditor Controller / City Financial Officer (PRINT)

Signature

10/28/2021
Date

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

MHSA COUNTY COMPLIANCE CERTIFICATION

County: County of San Diego

Local Mental Health Director	Program Lead
Name: Dr. Luke Bergmann, Ph. D.	Name: Nadia Privara Brahms
Telephone Number: 619-563-2766	Telephone Number: 619-584-5036
E-mail: Luke.Bergmann@sdcounty.ca.gov	E-mail: Nadia.Privara@sdcounty.ca.gov
County Mental Health Mailing Address: 3255 Camino Del Rio South, San Diego, CA 92108	

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this annual update, including stakeholder participation and nonsupplantation requirements.

This 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 draft 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 annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on October 5, 2021.

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 annual update are true and correct.

Luke Bergmann
Local Mental Health Director/Designee (PRINT)

Signature

10/15/2021
Date

County: San Diego

Date:

COUNTY OF SAN DIEGO
BOARD OF SUPERVISORS
TUESDAY, OCTOBER 05, 2021

MINUTE ORDER NO. 11

SUBJECT: RECEIVE AND APPROVE THE MENTAL HEALTH SERVICES ACT FISCAL YEAR 2021-22 ANNUAL UPDATE (DISTRICTS: ALL)

OVERVIEW

The Mental Health Services Act (MHSA) provides funding to counties to address a broad continuum of mental health service needs, including prevention, early intervention, and system development; and to address the necessary infrastructure, technology, and training to effectively support the public mental health system. MHSA programs provide services for children, youth, and families; transition age youth; adults; and older adults, with an emphasis on individuals who are unserved or underserved. MHSA is comprised of five components:

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

MHSA provides funding for critical programs that serve individuals with serious mental illness or serious emotional disturbance, supporting some of the San Diego County's most vulnerable populations of all ages and providing funding for previously unserved populations. MHSA supports timely access to quality behavioral health care that is responsive to cultural and linguistic needs. In support of the MHSA vision - to build a system in which mental health services are equitable, regionally distributed, and accessible to all individuals and families within the region who are in need - the County of San Diego (County), Health and Human Services Agency Behavioral Health Services (BHS) is pearheading work to proactively address and identify unmet behavioral health needs within the region, and the systemic and regional inequities that lead to these unmet needs.

BHS is in the second year of implementing the MHSA Three-Year Program and Expenditure Plan: Fiscal Years 2020-21 through 2022-23 (Three-Year Plan), approved by the San Diego County Board of Supervisors (Board) on October 27, 2020 (7). The MHSA Fiscal Year 2021-22 Annual Update (Annual Update) presented today includes budget and programmatic changes to the Three-Year Plan. The majority of services outlined in the Annual Update are a continuation of programs previously approved by the Board in the Three-Year Plan. As mandated by the MHSA, the Three-Year Plan and subsequent Annual Updates require approval by the Board prior to submission to the California Mental Health Services Oversight and Accountability Commission.

Since the establishment of the MHSA, the County has invested nearly $2 billion of MHSA funding to expand and enhance critical mental health programs to dramatically shift how residents of San Diego County access care and support for behavioral health needs through the continued development of a regionally distributed model of care focused on prevention and continuous care, rather than perpetual crisis. The County continues to make significant MHSA investments in critical prevention, treatment, and support services through the implementation of the Three-Year Plan and subsequent Annual Updates.

Today's action requests the Board receive and approve the Annual Update, which includes MHSA funding of approximately $218.6 million in Fiscal Year 2021-2022, inclusive of $400,000 dedicated to the California Mental Health Services Authority, to continue participation in statewide prevention and early intervention campaigns and local initiatives.

Today's action supports the countywide *Live Well San Diego* vision by enhancing access to behavioral health services, promoting well-being in children, adults, and families, and encouraging self-sufficiency, which promotes a region that is building better health, living safely, and thriving. MHSA supports improved access to treatment and care services for some of the region's most vulnerable, under-served, and under-resourced populations with the goal of reducing or eliminating the negative effects of the social determinants of health through a comprehensive continuum of behavioral health services. This supports the Board's Framework for Our Future through emphasizing processes designed to increase transparency, while providing inclusive services that yield better outcomes and opportunities for underrepresented communities.

RECOMMENDATION(S)
CHIEF ADMINISTRATIVE OFFICER
Receive and approve the MHSA Fiscal Year 2021-22 Annual Update (Annual Update) and authorize the Agency Director, Health and Human Services Agency, to submit the Annual Update to the California Mental Health Services Oversight and Accountability Commission.

EQUITY IMPACT STATEMENT
The vision of the Mental Health Services Act (MHSA) is to build a system in which mental health services are equitable, regionally distributed, and accessible to all individuals and families within the region who are in need. MHSA funding provides individuals who are experiencing serious mental illness or serious emotional disturbance with timely access to quality behavioral health care that is responsive to their cultural and linguistic needs. These programs serve individuals of all ages, providing support to San Diego County's most vulnerable, unserved, and underserved populations.

The community need for behavioral health services continues to increase, especially in the wake of the COVID-19 pandemic. Across demographics, psychological distress increased by over 200% from 2018 to 2020. Additionally, in findings published by the Journal of the American Medical Association, the prevalence of psychological distress was found to be more than twice as high among households making less than $35,000 annually versus those making $75,000 or more.

To guide clinical service design and placement, and to ensure effective outcomes are achieved, Behavioral Health Services (BHS) continues to enhance data integration and health equity work through the build out of data science and population health capacities. In addition, on an annual basis, through the Community Program Planning process, BHS collaborates with various councils, stakeholders, organizations, consumers, and other members of the community throughout San Diego County, which informs the MHSA process.

Furthermore, BHS is partnering with the University of California, San Diego to develop the Community Experience Project (CEP) with the purpose of identifying and addressing unmet behavioral health needs within the region, and the systemic and regional inequities that lead to these unmet needs.

The four objectives of the CEP include:
1. Creating a Behavioral Health Equity Index to highlight populations and neighborhoods at greatest risk for unmet behavioral health needs.

2. Developing an interactive Community Experience Dashboard that allows users to investigate behavioral health experiences by subpopulation (e.g., race/ethnicity, sexual orientation, etc.) and subregional area using timely community data sources.

3. Engaging community members and key stakeholders in the identification, collection, analysis, and interpretation of data and in the development of plans for action.

4. Developing brief, focused action reports to synthesize key findings and summarize priorities for intervention.

The final product will promote a continuous feedback process by which needs can be identified, further informed by community engagement, and mediated by actionable plans that will aid in informing the design of BHS services, including those funded through MHSA.

FISCAL IMPACT
Funds for this request are included in the Fiscal Year (FY) 2021-23 Operational Plan for the Health and Human Services Agency. If approved, this request will result in estimated MHSA costs and revenues of approximately $218.6 million in FY 2021-22, inclusive of $400,000 dedicated to the California Mental Health Services Authority (CalMHSA), to continue participation in statewide prevention and early intervention campaigns and local initiatives. The funding source is Mental Health Services Act (MHSA). There will be no change in net General Fund cost and no additional staff years.

BUSINESS IMPACT STATEMENT
N/A

ACTION:
ON MOTION of Supervisor Fletcher, seconded by Supervisor Desmond, the Board of Supervisors took action as recommended.

AYES: Vargas, Anderson, Lawson-Remer, Fletcher, Desmond

State of California)
County of San Diego) §

I hereby certify that the foregoing is a full, true and correct copy of the Original entered in the Minutes of the Board of Supervisors.

ANDREW POTTER
Clerk of the Board of Supervisors

Signed
by Andrew Potter

APPENDIX C

MHSA PROGRAM SUMMARIES

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	ALL-OE	Behavioral Health Services - Victims of Trauma and Torture	Survivors of Torture International	Outpatient mental health services to Adults/Older Adults who are victims of trauma and torture with serious mental illness and children who suffer from a severe emotional disturbance	Improve access to mental health services, culture specific, outreach and education to persons with a serious mental illness or emotional disturbance who have been victims of torture and provide referrals for victims of trauma and torture who are indigent and do not meet medical necessity	All ages of uninsured, unserved individuals with SED and SMI who are victims of trauma and torture.	• Bio-psychosocial rehabilitation services recovery • Strength based, client and family driven and culturally competent programs	Survivors of Torture International (619) 278-2400	All
CSS	ALL-OE	Behavioral Health Services and Primary Care Integration Services	Behavioral Health Services and Primary Care Integration	Provides services and treatment to adult patients with behavioral health problems through the Enhanced Screening, Brief Intervention and Referral to Treatment model	Provide effective, evidence-based treatment for behavioral health interventions in a primary care setting	Adults 18 years and older	• Mental health assessment • Dual diagnosis screening information • Brief mental health services • Linkages to services as needed	Community Clinic Health Network dba Health Quality Partners 3710 Ruffin Rd San Diego, CA 92123 (619) 542-4300	All
CSS	ALL-OE	Behavioral Health Services for Deaf & Hard of Hearing	Deaf Community Services	Adult outpatient mental health clinic provides video, secure email, and phone consultation in a mental health walk-in outpatient clinic within San Diego County	Assist clients who are deaf and hard of hearing to achieve a more adaptive level of functioning	Children, Transition Age Youth, Adults/Older Adults who are deaf or hard of hearing and who have a serious mental illness or substance use disorder	• Outpatient mental health services • Case management • Integrated substance use disorder treatment and rehabilitation	Deaf Community Services of San Diego Inc. 1545 Hotel Circle S., Suite 300 San Diego, CA 92108 (619) 398-2437	All
CSS	ALL-OE	Clubhouse - Deaf or Hard of Hearing	Deaf Community Services Clubhouse	Recovery and skill center/clubhouse for the Deaf or Hard of Hearing	Assist clients who are deaf and hard of hearing to achieve a more adaptive level of functioning	Transition Age Youth, Adults/Older Adults, who are deaf or hard-of-hearing who have or are at risk of a serious mental illness or co-occurring disorder	• Member-operated recovery and skill development clubhouse program • Services include social skill development, rehabilitative, recovery, vocational and peer support	Deaf Community Services of San Diego Inc. 1545 Hotel Circle S., Suite 300 San Diego, CA 92108 (619) 398-2437	All
CSS	ALL-OE	Psychiatric and Addiction Consultation and Family Support Services	Psychiatric and Addiction Consultation and Family Support Services SmartCare	Provides psychiatric and addiction consultation and family support services for primary care, pediatric and obstetric providers who serve patients with Medi-Cal or who are uninsured, throughout San Diego County, Transition Age Youth, Adults/Older Adults	Improve the confidence, competence, and capacity of primary care pediatrics, and obstetricians in treating behavioral health conditions; increase identification of behavioral health issues, including suicide risk; provide education, referrals, and linkages to support families	Children, Transition Age Youth, Adults/Older Adults	• Psychiatric and addiction consultation • Client education, referral, and linkage to services	Vista Hill Foundation 8825 Aero Dr, #315 San Diego, CA 92123 (858) 956-5906	All
CSS	ALL-SD	Chaldean and Middle-Eastern Social Services	Chaldean and Middle-Eastern Social Services	Outpatient mental health clinic provides treatment, rehabilitation, and recovery services to adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder	Provide culturally competent treatment, services and referrals for individuals of Middle Eastern descent who experience mental health issues or a serious mental illness	Adults 18 years and older and eligible for Medi-Cal funded services	• Outpatient mental health clinic which provides treatment, rehabilitation, and recovery services • Referrals and linkage support	Chaldean and Middle-Eastern Social Services 875 El Cajon Blvd. El Cajon, CA 92020 (619) 662-4100	2
CSS	ALL-SD	Psychiatric Emergency Response Team (PERT) EMT-MH Clinician Team	Psychiatric Emergency Response Team	Pairs law enforcement officers with licensed mental health clinicians to serve children and adults experiencing a behavioral health crisis and come have come in contact with law enforcement throughout the County	Improve collaboration between the mental health and law enforcement systems with the goal of more humane and effective handling of incidents involving law enforcement officers and mentally ill and developmentally disabled individuals	Children, Transition Age Youth, Adults/Older Adults, with a focus on veterans, homeless populations.	• Case coordination • Descalation and crisis intervention services • Training for law enforcement personnel	Community Research Foundation (CRF) 1202 Morena Blvd., Suite 300 San Diego, CA 92110 (619) 275-0892	All
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Rady Central Psychiatry Clinic	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital Central 3665 Kearny Villa Rd., Suite 101 San Diego, CA 92123 (858) 966-5832	4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Community Circle Central and East	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Family Health Centers - Logan Heights 2204 National Ave. San Diego, CA 92113 (619) 515-2382 3845 Spring Dr. Spring Valley, CA 91977 (619) 255-7520	1,2,4

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Community Research Foundation - Crossroads Family Center	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Community Research Foundation Crossroads Family Center 700 N. Johnson Ave, Suite P El Cajon, CA 92020 (619) 441-1907	2
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Community Research Foundation - Mobile Adolescent Services Team (MAST)	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment. Housing case management component for chidlren and families in the Monarch program.	Provide a full range of family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who may be attending a Juvenile Court and Community School (JCCS) and meet medical necessity and serious emotional disturbance (SED) criteria.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Community Research Foundation Mobile Adolescent Services Team 1202 Morena Blvd., Suite 100 San Diego, CA 92110 (619) 398-3261	All
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Community Research Foundation - Nueva Vista Family Service	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Community Research Foundation Nueva Vista Family Services 1161 Bay Blvd., Suite B Chula Vista, CA 91911 (619) 585-7686	1
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Counseling and Treatment Center - School Based Outpatient Children's Mental Health Services	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Homeless children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Union of Pan Asian Communities (UPAC) Children's Mental Health 1031 25th St., Suite C San Diego, CA 92102 (619) 232-6454	4, 5
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Community Research Foundation - Douglas Young Youth and Family Services	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offer case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Community Research Foundation Douglas Young Youth and Family Services 7907 Ostrow St., Suite F San Diego, CA 92111 (858) 300-8282	3, 4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	East County Behavioral Health Clinic	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offer case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	San Diego Youth Services 1870 Cordell Ct., Suite 101 El Cajon, CA (619) 448-9700	2
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	East County Outpatient Counseling Program	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	San Diego Center for Children East Region Outpatient 7339 El Cajon Blvd., Suite K La Mesa, CA 91942 (619) 668-6200	2
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Foster Family Agency Stabilization and Treatment (FFAST)	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21, involved in Child Welfare Services and residing in Foster Family Agency homes, who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	San Diego Center for Children FFAST 8825 Aero Dr., Suite 110 San Diego, CA 92123 (858) 633-4102 North County 145 Vallecitos de Oro, Suite 210 San Marcos, CA 92069 (858) 633-4115	All

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Learning Assistance Center	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Vista Hill Foundation - Escondido 1029 N. Broadway Ave. Escondido, CA 92026 (760) 489-4126 Vista Hill Foundation - North Inland Ramona 1012 Main St., Suite 101 Ramona, CA 92065 (760) 788-9724	2, 3, 5
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Merit Academy Day School Services	Day School Services provides individual, group and family services at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Vista Hill 1600 N. Cuyamaca St. El Cajon, CA 92020 (619) 994-7860	2
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Multi-Cultural Community Counseling - Full Service Partnership (FSP)	Culturally specific individual/group/family services provided at home, community or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment. The focus of this program is to provide services to underserved Asian Pacific Islander (API) and Latino clients with Serious Emotional Disturbance with an emphasis on API clients.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	•Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Union of Pan Asian Communities (UPAC) Children's Mental Health 1031 25th St., Suite C San Diego, CA 92102 (619) 232-6454	All
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	North County Lifeline	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	North County Lifeline - Vista 200 Michigan Ave. Vista, CA 92084 (760) 726-4900 North County Lifeline - Oceanside 707 Oceanside Blvd. Oceanside, CA 92054 (760) 757-0118	3, 5
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Palomar Family Counseling Services	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Palomar Family Counseling 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660 120 West Hawthorne St. Fallbrook, CA 92028 (760) 731-3235	2, 3, 5
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Para Las Familia	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 5 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Outreach and Engagement	Episcopal Community Services Para Las Families 1424 30th St., Suite A San Diego, CA 92154 (619) 565-2650	1
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Pathways Cornerstone	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Pathways Cornerstone School Based Outpatient Treatment 6244 El Cajon Blvd., Suite 14 San Diego, CA 92115 (619) 640-3269	4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Rady Outpatient Psychiatry North Coastal	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offer case management, family or youth partner support, and/or co- occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital North Coastal 3142 Vista Way, Suite 205 Oceanside, CA 92056 (760) 758-1480	3, 5

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Rady Outpatient Psychiatry North Inland	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital North Inland 625 W. Citacado Pkwy., Suite 102 Escondido, CA 92025 (760) 294-9270	2,3,5
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	MHS - Community and School Based Counseling	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Mental Health Systems Inc. School Based Program 4660 Viewridge Ave. San Diego, CA 92123 (858) 278-3292	3, 4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	School-Based Central-East-South	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital Central-East-South 3665 Kearny Villa Rd., Suite 101 San Diego, CA 92123 (858) 966-8471	1, 2, 4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	South Bay Community Services (Mi Escuelita)	Individual/group/family services provided at home, community or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	South Bay Community Services 430 F St. Chula Vista, CA 91910 (619) 420-3620	1
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	TIDES	Individual/group/family services provided at home, community or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance use treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 and their families who are underserved with a focus on Latino and Asian-Pacific Islanders	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	YMCA-TIDES 4394 30th St. San Diego, CA 92104 (619) 543-9850	4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Youth Enhancement Services	Individual/group/family services provided at home, community or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	San Ysidro Health Center Youth Enhancement Services 3025 Beyer Blvd., Suite E-101 San Diego, CA 92154 (619) 428-5533	1
CSS	CY-FSP	Children's Full Service Partnership (FSP)	NewLife Counseling	Locates and engages homeless and runaway youth for the purpose of increasing access to mental health services and family reunification. Individual/group/family services provided at schools, community, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Homeless children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	North County Lifeline Inc. NewLife Counseling 200 Michigan Ave. Vista, CA 92084 (TBD)	All
CSS	CY-FSP	Therapeutic Behavioral Services (TBS)	Therapeutic Behavioral Services	Critical short term one-to-one behavioral intervention services for full Medi-Cal children up to 21 years old, and Full Service Partnership (FSP), who are experiencing a current emotional or behavioral challenge or experiencing a stressful life transition.	Return children/youth to their family or family-like setting, support permanency and enhance long-term success	Children up to age 21 who are Medi-Cal eligible and who are receiving specialty mental health reimbursable services and experiencing a current emotional or behavioral challenge or experiencing a stressful life transition.	• One on one behavioral coaching	New Alternatives - TBS 8755 Aero Drive, Suite 230 San Diego, CA 92123 (858) 256-2180	All

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	CY-FSP	Wraparound Services (WRAP) - Child Welfare Services (CWS)	WrapWorks	Wraparound offers team based intensive and individualized case management to a child or youth within the context of their support system, leveraging both formal and informal supports	Return children/youth to their family or family-like setting, support permanency and enhance long-term success	Children and youth up to age 21 who are involved with Child Welfare Services or Probation	• Case management and rehabilitative services • Intensive care coordination • Intensive home-based services • Crisis intervention • Medication management • Outreach at schools and the community	San Diego Center for Children 3002 Armstrong Street San Diego, CA 92111 (858) 569-2170 **North** 235 W 5th Avenue, Suite 130 Escondido, CA 92025 **South** 3322 Sweetwater Spring Blvd, Suite 104 Spring Valley, CA 929177	All
CSS	CY-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Women	TBD	Women and perinatal substance use disorder treatment	Perinatal outpatient substance use disorder and co-occurring treatment and recovery services	Women, pregnant and parenting women, and adolescent females ages 15 and older	• Recovery services	TBD	All
CSS	CY-OE	Parent Partner Services	Family/Youth Support Partnership Services	Provide case management, focus groups, support and education groups and community resource fairs provided by a Youth / Family Support Partner (YFSP) and linking them to needed behavioral health treatment and education.	Outreach and Engagement services for children, youth, up to age 21, and their families	Latino, Asian, and African American children and youth up to age 21	• Outreach and Engagement • Family Support Partners • Case management • Focus groups • Support and Education Groups • Community Presentations	Harmonium 5275 Market St, Ste E San Diego, CA 92114 (858) 226-1982	4
CSS	CY-SD	Adolescent Day Rehabilitation	San Diego Center for Children Residential Outpatient Children's Mental Health Services	Individual/group/family services to children and youth in a residential setting. Provides Independent Living Skills services to Child Welfare Services youth in placement. These services result in integrated treatment services for youth with co-occurring mental health substance use disorders	Return children/youth to their family or family-like setting; deter children/youth from placement in a higher level of care; and stabilize current placement	Children and youth up to age 18, residing at San Diego Center for Children, who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Medication services • Independent Living Skills	San Diego Center for Children 3003 Armstrong St. San Diego, CA 92111 (858) 277-9550	All
CSS	CY-SD	BHS Children, Youth and Families (CYF) Liaison	Family Youth Liaison (YL)	The Family Youth Liaison collaborates with Children, Youth and Families (CYF) administrative staff to ensure family and youth voice and values are incorporated into service development, implementation plans, and service delivery	Advance, train, and coordinate family/youth partnership in CYF programs	Children and youth up to age 21 served by CYF providers and their families	• Coordinates administrative functions in which family/youth participate • Trains CYF programs management staff to work with support Family/Youth Partners • Develops and provides CYF system trainings and coaching sessions • MHSA Issue Resolution point of contact	National Alliance on Mental Illness (NAMI), San Diego 5095 Murphy Canyon Rd., Suite 320 San Diego, CA 92123 (858) 634-6580	All
CSS	CY-SD	BridgeWays Program	BridgeWays Program Services	Individual/group/family services provided at office/clinic, home, school or other community locations. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families who are at risk of involvement or currently involved in the Juvenile Justice System	Children and youth up to age 21, who are at risk of involvement or currently involved in the Juvenile Justice System, who meet medical necessity and serious emotional disturbance (SED) criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Home Based Services • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement • Substance use services	San Diego Youth Services BridgeWays 7364 El Cajon Blvd. San Diego, CA 92115 (619) 221-8600 x2503	All
CSS	CY-SD	Commercially Sexually Exploited Children (CSEC)	San Diego Youth Services - I CARE	Individual/group/family services provided at schools, home, drop-in center or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment. Supportive services at drop-in center	Provide a full range of family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health and supportive services to children, youth and their families that are at risk for or are victims of commercial sexual exploitation	Children and youth up to age 21 who are at risk for or are victims of commercial sexual exploitation and who meet medical necessity and serious emotional disturbance (SED) criterial. Any at risk for or victim of commercial sexual exploitation who would benefit from supportive services at the drop-in center	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement • Assistance with housing • Job skill assessment • GED preparation • Support groups • Youth Partners • Mentors	San Diego Youth Services I CARE 3660 Fairmount Ave. San Diego, CA 92105 (619) 521-2550 x 3816	All
CSS	CY-SD	County of San Diego - Probation	Probation After Hours (STAT Team)	Multi-disciplinary team provides transitional services as youth rejoin the community following incarceration	Ensure probation children and youth with mental illness have access to mental health services, with successful reintegration into the community and potential reduction in recidivism	Probation children and youth up to age 21 currently in detention or in the community who require mental health services to enhance functioning and reduce symptomology	• Individual/group/family treatment • Crisis intervention • Care coordination • Case management • Medication management • Community based mental health services	Probation Administration 9444 Balboa Ave. San Diego, CA 92123 (858) 514-3148	All

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	CY-SD	Crisis Action and Connection	Crisis Action and Connection	Provides intensive support and linkage to services and community resources for children/youth who have had a recent psychiatric episode	Improve the ability of children and youth and their families to access and benefit from mental health services in order to divert or prevent readmission to acute services	Children and youth up to age 21 who meet medical necessity and meet set criteria	• Intensive case management and treatment to stabilize high risk youth • Crisis intervention • Medication services • Case Management	New Alternatives Inc. Crisis Action & Connection 730 Medical Center Crt. Chula Vista, CA 91911 (619) 591-5740	All
CSS	CY-SD	Emergency Screening Unit (ESU)	Emergency Screening Unit (ESU)	Provides crisis stabilization to children and youth experiencing a psychiatric emergency	Reduce the use of emergency and inpatient services, prevent escalation, and promote the management of mental illness	Children and youth under age 18 who are experiencing a psychiatric emergency	• Crisis stabilization services for high risk youth • Crisis intervention • Medication services	New Alternatives Inc. Emergency Screening Unit 4309 Third Ave. San Diego, CA 92103 (619) 876-4502	All
CSS	CY-SD	Incredible Families	Incredible Families	Behavioral health outpatient services and other developmental appropriate clinical interventions to children and their families that are Dependents of the Juvenile Courts hence involved with Child Welfare Services (CWS).	Return children/youth to their family or family-like setting; deter children/youth from placement in a higher level of care; and stabilize current placement	Families and their children 2-14 years old who are dependents of Juvenile Dependency Court due to abuse and/or neglect	• Weekly multi-family parent and child visitation event and meal for all family members • Utilization of the Incredible Years evidence-based curriculum • A primary therapist is assigned to each family • Clinical support during family visitation events, as well as, during individual and family therapy	New Alternatives Inc. Incredible Families Central 8765 Aero Dr Suite 310A, San Diego, CA 92123 (619) 207-0396 Incredible Families North 1020 S. Santa Ana Ave Suite D-1, Vista, CA 92084 Incredible Families South 730 Medical Center Court, Chula Vista, CA 91911	All
CSS	CY-SD	Incredible Years	Children Seriously Emotionally Disturbed	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management and family partner support	Provide a full range of family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children through five years old, and their families, using the Incredible Years evidence-based program.	Children through age 5 who meet medical necessity and serious emotional disturbance criteria, and their families	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Palomar Family Counseling 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660	2, 3, 5
CSS	CY-SD	Medication Support for Wards and Dependents	Vista Hill - Juvenile Court Clinic	Provides short term (no more than three months) individual/family treatment, psychotropic medication and linkage to community-based provider for on-going treatment to children and youth who may be involved in the juvenile justice or child welfare systems	Assist the youth and family with stabilization, support, linkage and coordination to community provider for ongoing mental health services if needed	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria and who are in the juvenile justice or child welfare systems	• Individual/family treatment • Care coordination • Case management • Rehabilitative services • Medication services	Vista Hill Juvenile Court Clinic 2851 Meadow Lark Dr. San Diego, CA 92123 (858) 571-1964	All
CSS	CY-SD	Mental Health Services - For Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ)	San Diego Youth Services - Our Safe Place	Individual/group/family services provided at schools, home, drop-in center or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment. Supportive services at 4 drop-in centers	Provide a full range of family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health and supportive services to children, youth who identify as LGBTQ and their families	LGBTQ children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria. Any LGBTQ youth who would benefit from supportive services at the drop-in centers	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement • Assistance with housing • Job skill assessment • General Education Diploma (GED) preparation • Support groups • Youth Partners • Mentors	San Diego Youth Services Our Safe Place 3427 4th Ave. Second Floor San Diego, CA 92103 (619) 525-9903	All
CSS	CY-SD	Peer Mentoring	San Pasqual Academy Children's Mental Health Services	Full day rehabilitation and peer mentor services to San Pasqual Academy residents who are dependents of the Court.	Provide full day rehabilitation and peer mentor services to San Pasqual Academy residents to ensure clients have a stable living environment in order to complete their schooling and eventually transition to a home-like enviornment.	Residents of San Pasqual Academy 12-21 years old who meet medical necessity and are dependents of the Court.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Medication services • Independent Living Skills	New Alternatives Inc. San Pasqual Academy 17701 San Pasqual Valley Rd. Escondido, CA 92025 (760) 233-6003	All
CSS	CY-SD	Placement Stabilization Services	Comprehensive Assessment and Stabilization Services (CASS)	Outpatient mental health services including a comprehensive behavioral health assessment, individual and family therapy, casemanagement, individual rehab and psychiatric services/med management for children and youth placed by Child Welfare services in a resource family home and at risk of change of placement disruption.	Stabilize current placement, deter children and youth from placement in a higher level of care and support transition of children and youth back to their biological families	Foster children and youth up to age 18 who recently experience placement disruption and meet medical necessity and serious emotional disturbance criteria.	• Assessment • Case management and rehabilitative services • Intensive care coordination • Intensive home-based services • Crisis intervention • Medication management • Outreach at schools and the community	New Alternatives Inc. 3517 Camino Del Rio South, Suite 407 San Diego, CA 92108 (619) 955-8905	All

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	CY-SD	Placement Stabilization Services	Polinsky Children's Center Outpatient Services (PCC)	Outpatient mental health services including a comprehensive behavioral health assessment and short-term individual therapy, case management, individual and group rehab and psychiatric services/med management for children and youth placed at County ten day assessment center, Polinsky Children's Center.	Return children and youth to their family or family-like setting, support permanency and link children, youth and families to support services when indicated	Children and youth up to age 18 who meet medical necessity and serious emotional disturbance criteria brought to Polinsky Children's Center by Child Welfare for a short assessment period	• Assessment • Case management and rehabilitative services • Intensive care coordination • Intensive home-based services • Crisis intervention • Medication management • Outreach at schools and the community	New Alternatives Inc. 9400 Ruffin Ct. San Diego, CA 92123 (858) 598-5035	All
CSS	CY-SD	Rural Integrated Behavioral Health and Primary Care Services	Rural Integrated Behavioral Health and Primary Care Services	Paraprofessionals within rural community clinics provide behavioral health education to prevent development of serious mental illness or addiction. Services provided may also include short-term prevention services and community referrals to support early intervention.	Prevention and early intervention education to prevent development of serious mental health or addiction for children, transitional age youth and adults/older adults	Children, Transition Age Youth, Adults/Older Adults	• Education • Mobile outreach	Vista Hill Foundation 1012 Main Street, #101 Ramona, CA (760) 788-9725	2, 5
CSS	TAOA-FSP	Full Partnership (FSP) / Assertive Community Treatment (ACT) Institutional Case Management (ICM)	Telecare Agewise	Strengths-Based Case Management, Full Service Partnership program for Older Adults in addition to having an Institutional case management component	Increased access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services plus assist clients in long term care to graduate and be placed in the community	Adults 60 years and older with a serious mental illness who may be on LPS Conservatorship or who have needs that cannot be adequately met by a lower level of care	•Care coordination and rehabilitation • Field-based services have a participant-to-staff ratio that is approximately 25 to 1 • Case management and supportive housing (when available)	Telecare Corporation Telecare Agewise 6160 Mission Gorge Road, Suite 108 San Diego, CA 92120 (619) 481-5200	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	North Coastal ACT	Provides an Assertive Community Treatment, Full Service Partnership program for persons 18 years and older who have been very high users of Medi-Cal hospital psychiatric services and/or institutional care	Provide Assertive Community Treatment Services to persons with very serious mental illness	Adult 18 years and older with very serious mental illness who have been high users of Medi-Cal psychiatric hospital services and/or institutional care, including those with co-occurring substance use disorder	• Assertive Community Treatment intensive, multidisciplinary treatment services for persons who have a very serious mental illness and needs that cannot be adequately met through a lower level of care • Includes housing component	Mental Health Systems Inc. (MHS) 2122 El Camino Real #102 Oceanside, CA 92054 (760) 290-8170	5
CSS	TAOA-FSP	Adult Residential Treatment	Changing Options	Residential facility for adults with serious mental disorders	Maximize each individual's recovery in the least restrictive environment through a comprehensive medical, psychological, and social approach to assist the client's recovery and return to independent living.	Adults 18 years and older with disabling psychiatric disorder requiring a 24-hour Mental Health Rehabilitation Center	• Psycho-educational and symptom/wellness groups • Employment and education screening/readiness • Skill development • Peer support, and mentoring • Physical health screening • Referrals	Changing Options Inc. 500 Third St. Ramona, CA 92065 (760) 789-7299	All
CSS	TAOA-FSP	Assisted Outpatient Treatment (AOT)	Assisted Outpatient Treatment (AOT)	Intensive community-based services for persons who establish an Assisted Outpatient Treatment court settlement agreement, persons who are court-ordered, persons who otherwise meet the eligibility criteria and voluntarily accept alternative services prior to an Assisted Outpatient Treatment petition being filed	Integrate behavioral health and rehabilitation treatment and recovery services for adults with a serious mental illness and have been identified as potential candidates by the In-Home Assessment Team, have agreed to an Assisted Outpatient Treatment court settlement, or have Assisted Outpatient Treatment status resulting from a contested court hearing	Adults 18 years and older meeting Title 9 criteria as established under Laura's Law	• Assertive Community Treatment with a rehabilitation and recovery focus	Telecare Corporation 1660 Hotel Circle N., Suite 101 San Diego, CA 92108 (619) 481-3840	All
CSS	TAOA-FSP	Behavioral Health Court	Collaborative Behavioral Health Court	Uses the Assertive Community Treatment model to enhance the lives of individuals experiencing a serious mental illness and co-occurring conditions through case management and mental health services	Integrate mental health, substance-induced psychiatric disorder rehabilitation treatment, and recovery services for adults with serious mental illness to improve their mental health, quality of life in the community, and prevent recidivism in the criminal justice system	Underserved adults,18 years and older, with serious mental and/or substance-induced psychiatric disorder illnesses, who have been incarcerated and are misdemeanor or felony offenders	• Team-based management • Peer support specialist • Medication management • Health care integration services • Linkage to services in the community • Housing subsidy • Providing education/vocational services and training	Telecare Corporation 4930 Naples St. San Diego, CA 92110 (619) 276-1176	4
CSS	TAOA-FSP	County of San Diego - Institutional Case Management (ICM)	Institutional Case Management	Provides 5 Full Time Equivalent positions of Institutional Case Management	Stabilization and linkage to services	Children, Transition Age Youth, Adults/Older Adults	• Case Management	County of San Diego	All
CSS	TAOA-FSP	County of San Diego - Probation	Probation Officer for Behavioral Health Court	Probation Office for Behavioral Health Court	Stabilization and linkage to services	Transition Age Youth, Adults/Older Adults	• Transition services	County of San Diego	All
CSS	TAOA-FSP	County of San Diego - Probation	Probation-FSP-ACT Team	Interventions, case management, and supervision of juveniles and adults who are at risk of entering the justice system or re-offending while placed on probation by the courts	Reduce incarceration and institutionalization, provide timely access to services, and reduce homelessness	Transition Age Youth and Adults who have a serious mental illness	• Mental health assessments • Interventions • Case Management • Outreach and engagement	Probation Administration 9444 Balboa Ave. San Diego, CA 92123 (858) 514-3148	All
CSS	TAOA-FSP	Crisis Residential Services - North Inland	Esperanza Crisis Center	Twenty-four hours a day, seven days a week service provided as an alternative to hospitalization or step down from acute inpatient care within a hospital for adults with acute symptoms of serious mental illness, including those who may have a co-occurring substance use disorder	Provide alternative to hospital or acute inpatient care	Voluntary adults 18 years and older with acute and serious mental illness, including those who may have a co-occurring substance use disorder	• Crisis residential services as an alternative to hospitalization or step down from acute in-patient care within a hospital	Community Research Foundation 337 West Mission Ave. Escondido, CA 92025 (760) 975-9939	All

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	IMPACT Downtown IMPACT	Fully integrated and wrap around services to clients diagnosed with a serious mental illness, as well as individuals with co-occurring, mental health and substance disorders	Improve the mental health and quality of life of adults in the community who have been or as-risk of becoming homeless and have a serious mental illness by increasing clinical and functional stability through an array of mental health services, housing opportunities and educational and employment supports	Adults 18-59 who are homeless or at risk of homelessness, have serious mental illness (SMI), and who may also have a co-occurring condition of substance use in the Central and North Central Regions of San Diego	• Linkage to food, housing and/or physical health services • Medication management •Vocational services • Substance use disorder services • Includes housing component	IMPACT 1260 Morena Blvd., Suite 100 San Diego, CA 92110 (619) 398-2156 Downtown IMPACT 995 Gateway Center Way, Suite 300 San Diego, CA 92102 (619) 398-2156	1, 4
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACTION Central	The 100 Homeless Project is a collaborative effort between the County of San Diego and San Diego Housing Commission which provides a hybrid integrated service model to homeless individuals with a serious mental illness who may have a co-occurring diagnosis of substance use disorder	Integrate wrap-around services with accessible housing that supports the homeless population	Homeless Transition Age Youth, Adults/Older Adults who have a serious mental illness and may have a co-occurring diagnosis of substance use disorder	• Medication management and monitoring Individual therapy • Outpatient substance use disorder treatment • Intensive case management, Employment support • Peer counseling • Supportive housing component	Metal Systems Inc. (MHS) ACTION Central 6244 El Cajon Blvd., Suite 15-18 San Diego, CA 92115 (858) 380-4676	1
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACTION East	This homeless project is a collaborative effort between the County of San Diego and Housing and Community Development which provides a hybrid integrated service model to homeless individuals with a serious mental illness who may have a co-occurring diagnosis of substance use disorder	Provide permanent supportive housing services integrated with serious mental illness (SMI) and substance use disorder (SUD) treatment services for the homeless in East Region. This hybrid program provides Assertive Community Treatment Services to persons with serious mental illness who may also have a co-occurring use disorder.	Homeless Transition Age Youth, Adults/Older Adults with a serious mental illness who may have a co-occurring diagnosis of substance use disorder	• Mental health rehabilitation Treatment and recovery services for clients with substance use disorder • Integrated case management services with substance use disorder treatment and recovery services • Supportive housing component	Mental Health Systems Inc. (MHS) ACTION East 10201 Mission Gorge Rd., Suite O Santee, CA 92071 (619) 383-6868	2
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Center Star ACT	24-hour community -based treatment for individuals with a criminal justice background who have been diagnosed with a severe and persistent mental illness	Provides Assertive Community Treatment Services to persons with very serious mental illness	Adults 25 to 59 years old who have a serious mental illness and adults 18 years and older who may have been homeless	• Clinical case management Mental health services with a rehabilitation and recovery focus • Supportive housing • Educational and employment development • Individual and group rehabilitation counseling • Psychiatric assessment	Mental Health Systems Inc. (MHS) 4283 El Cajon Blvd., Suite 115 San Diego, CA 92105 (619) 521-1743	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Project One-for-All POFA 100 City Star	Full Service Partnership Assertive Community Treatment team and recovery services program will use a "Housing First" approach	Provide Assertive Community Treatment Services to persons with serious mental illness who may also have a co-occurring use disorder. Services are provided by a multi-disciplinary team of professional and paraprofessional staff.	Transition Age Youth, adults 18 and older who are homeless, have serious mental illness and who may have a co-occurring diagnosis of substance abuse	• Clinical case management Mental health services with a rehabilitation and recovery focus • Supportive housing • Educational and employment development • Individual and group rehabilitation counseling • Psychiatric assessment	Mental Health Systems Inc. (MHS) 8775 Aero Dr., Suite 132 San Diego, CA 92123 (858) 609-8742	4
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Project One-for-All POFA South Region (100 SMI Slots) Housing	Full Service Partnership Assertive Community Treatment team and recovery services Program will use a "Housing First" approach	Ensure clients are provided access to good quality housing in the South Region of San Diego County	Transition Age Youth, adults 18 and older who are homeless, have serious mental illness and who may have a co-occurring diagnoses of substance abuse	• Supportive Housing	Adelante (CRF) 855 Third Ave., Suite 1110 Chula Vista, CA 91911 (619) 934-5770	1
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Gateway to Recovery	Provides an Assertive Community Treatment, Full Service Partnership program for person 18 years and older who have been very high users of Medi-Cal hospital psychiatric services and/or institutional care	Provide Assertive Community Treatment Services to persons with very serious mental illness who may also have a co-occurring use disorder. This contract also serves persons who have been referred by Probation as AB109 Post Release Offenders (PROs) and Mandatory Supervision Offenders (MSOs) who have a serious mental illness.	Adults 18 years and older with very serious mental illness who have been high users of Medi-Cal psychiatric hospital services and/or institutional care, including those with co-occurring substance use disorder	• Assertive Community Treatment intensive, multidisciplinary treatment services for who have a very serious mental illness and needs that cannot be adequately met through a lower level of care • Probation-funded Assertive Community Treatment component • Includes housing component	Telecare Corporation 3132 Jefferson St. San Diego, CA 92110 (619) 683-3100	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	North Star - Strengths Based Case Management (SBCM)	Full Service Partnership Strengths-Based Case Management	Recovery-oriented strengths-based clinical case management services to persons with serious mental illness	Adults 25 to 59 years old who have a serious mental illness, are homeless or at risk of homeless	• Strengths based case management	Mental Health Systems Inc. (MHS) Escondido 474 W. Vermont Ave., Suite 104 Escondido, CA 92025 (760) 294-1281	3, 5

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Pathways to Recovery	Assertive Community Treatment and In-Reach for adults in and discharged from long-term care	Provide Assertive Community Treatment Services to persons with serious mental illness who may also have a co-occurring use disorder. Services are provided by a multi-disciplinary team of professional and paraprofessional staff such as: counselors, social workers, peer specialist, vocational specialist, housing specialists, nurses, physician's assistants, medical doctors, and substance use disorder specialists.	Adults 18-59 years old with serious mental illness and are, or recently have been, in a long-term care institutional setting	• Provide Assertive Community Treatment Team • Multidisciplinary, wraparound treatment and rehabilitation services for adults discharged from long-term care facilities who have a serious mental illness and needs that cannot be adequately met through a lower level of care • Includes an in-reach component for some persons served by the county institutional case management program • Includes housing component	Telecare Corporation 3132 Jefferson St. San Diego, CA 92110 (619) 683-3100	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Senior IMPACT	Offers intensive, comprehensive, community - based integrated behavioral health services	Increase timely access to services and supports to assist Older Adults and family/ caregivers in managing independent living, reducing isolation, improving mental health, and remaining safely in their homes	Adults 60 years and older who are homeless or at risk of homelessness and have serious mental illness	• Linkage to food, housing and/or physical health services • Medication management • Vocational services • Substance use disorder services • Includes housing component	Community Research Foundation (CRF) - Senior IMPACT 928 Broadway San Diego, CA 92102 (619) 977-3716	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Vida ACT	Full Service Partnership/Assertive Community Treatment - Justice Involved	Provides Assertive Community Treatment Services to persons with serious mental illness who are justice involved	Adults,18 years and older, with serious mental and/or substance-induced psychiatric disorder illnesses, who have been incarcerated and are misdemeanor or felony offenders	• Clinical case management Mental health services with a rehabilitation and recovery focus • Supportive housing • Educational and employment development • Individual and group rehabilitation counseling • Psychiatric assessment	Telecare Corporation 3491 Kurtz Street, Suite 150 San Diego, CA 92110	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Catalyst	Transition Age Youth Assertive Community Treatment Full Service Partnership. Services are team-based, available around the clock, are primarily delivered on an outreach basis, and have a participant-to-staff ratio that is approximately 10-12 to 1	Provide Assertive Community Treatment Team intensive, multidisciplinary, wraparound treatment and rehabilitation services for Transitional Age Youth who have a serious mental illness, may be on LPS Conservatorship, and have needs that cannot be adequately met through a lower level of care	Transition Age Youth with a serious emotional disturbance or serious mental illness (who may have a co-occurring mental illness and substance use disorder) that have been homeless or may be at risk of being homeless	• Assertive Community Treatment (ACT) mental health • Includes housing component	Pathways Community Services 7986 Dagget St. San Diego, CA 92111 (858) 300-0460	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step down from IMD	La Luz	Full Service Partnership/Assertive Community Treatment	Provide Assertive Community Treatment Services to persons with serious mental illness, who maybe have a substance use disorder, are homeless or at risk of homelessness, who are discharging from long term care (IMD, Skilled Nursing Facility, State Hospital)	Adults 18 years and older who have serious mental illness, including those who may have a co-occurring substance use disorder and justice involved	• Assertive Community Treatment Services • Includes housing component	Telecare La Luz 3489 Kurtz, San Diego, CA 92110 619-320-2404	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	Casa Pacifica	Transitional residential program serves abused and neglected children and adolescents, and those with severe emotional, social, behavioral, and mental health challenges	Increase independent living and reduce hospitalizations through educational and employment opportunities	Adults/Older Adults who are homeless with a serious mental illness	•Medication Support • Case management/Brokerage • Crisis intervention • Rehabilitative and recovery interventions in a transitional residential setting	Casa Pacifica 321 Cassidy St. Oceanside, CA 92054 (760) 721-2171	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	Hummingbird Healing House	Full Service Partnership/Assertive Community Treatment - Transitional Residential and Adult Residential Facility. Program provides transitional residential beds and bio-psychosocial rehabilitative services to adults with a serious mental illness and co-occurring disorders.	Provide transitional residential beds and bio-psychosocial rehabilitative services to adults with a serious mental illness and co-occurring disorders.	Adults eighteen (18) years of age or older, with primary serious mental illness diagnosis	• Functional adaptation skills training; • Integrated co-occurring disorder services; • Wellness Recovery Action Plan; • Cognitive Behavioral Therapy and Dialectical Behavioral Therapy; • Problem solving • Independent living skills	Crestwood Behavioral Health, Inc. 5550 University Ave, Suite A San Diego, Ca 92105 (619) 481-5447	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from Acute	Tesoro	Full Service Partnership/Assertive Community Treatment - Transitional Residential and Adult Residential Facility	Provide Assertive Community Treatment Services to persons with serious mental illness, who maybe have a substance use disorder, are homeless or at risk of homelessness, who are discharging from acute behavioral health hospital.	Adults 18 years and older who have serious mental illness, including those who may have a co-occurring substance use disorder	• Assertive Community Treatment Services • Includes housing component	Telecare Tesoro 3489 Kurtz, San Diego, CA 92110 619-320-2404	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	Uptown Safe Haven	Residential transitional housing program that provides supportive services for those who are experiencing homelessness and have a serious mental illness	Provide residential support, crisis intervention, and transitional housing services to clients experiencing homelessness who are enrolled in Assertive Community Treatment (ACT) services.	Adults/Older Adults with a serious mental illness who are experiencing homelessness	• Transitional housing for eligible individuals • Provide food • Case management	Uptown Safe Haven 2822 5th Ave. San Diego, CA 92103 (619) 294-7013	All

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	North Start ACT SBCM	Full Service Partnership/Assertive Community Treatment with supportive housing and Strengths-Based Case Management. Project-One-For-All (POFA) 100 Central/North Housing	Reduce homelessness and provide comprehensive ACT 'wraparound' mental health services for adults with most severe illness, most in need due to severe functional impairments, and who have not been adequately served by the current system	Adults 25 to 59 years old who have a serious mental illness, are homeless or at risk of homeless. Adults 18-59 years old who are eligible for Medi-Cal funded services or are indigent	• Strengths-based case management • Rehabilitation and mental health services with a focus on adults who meet eligibility criteria • Supportive housing component	Mental Health Systems Inc. (MHS) Escondido 474 W. Vermont Ave., Suite 104 Escondido, CA 92025 (760) 294-1281	3,5
CSS	TAOA-FSP	Short-Term Mental Health Intensive Case Management - High Utilizers	Transition Team	Provides Short-term Intensive Transition Team to serve individuals who are or have recently been hospitalized	Provide Assertive Community Treatment Services to persons with very serious mental illness	Adults 18 years and older	• Short-term Intensive Transition Team	Telecare Corporation 3132 Jefferson St. San Diego, CA 92110 (619) 683-3100	All
CSS	TAOA-FSP/SD	Strengths Based Case Management (SBCM) Bio-Psychosocial Rehabilitation (BPRS)	Maria Sardinas Center	South Region (Southern Area) strengths-based case management	Provide strengths-based case management services to persons with serious mental illness	Adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder. Transition Age Youth population and Probation-funded AB 109 component	• Outpatient mental clinic • Strengths-based case management	Maria Sardinas Wellness & Recovery Center 1465 30th St., Suite K San Diego, CA 92154 (619) 428-1000	1
CSS	TAOA-FSP/SD	Strengths Based Case Management (SBCM) Bio-Psychosocial Rehabilitation (BPRS)	South Bay Guidance Wellness and Recovery Center	South Region (Northern Area) strengths-based case management	Provide strengths-based case management services to persons with serious mental illness	Adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder	• Outpatient mental clinic • Strengths-based case management	South Bay Guidance Wellness and Recovery Center 1196 3rd Ave., Chula Vista, CA 91911 (619) 427-4661	1
CSS	TAOA-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Adult	Bridges North Central	Non-residential substance use disorder treatment and recovery service center. Incorporating evidence-based treatment and recovery services	Ensure that adults experiencing co-occurring substance use disorder and mental health problems receive services that comprehensively address both disorders, so the individual may achieve a substance use disorder free lifestyle	Adults 18 years and older with substance use disorder, including those who may have co-occurring mental health	• Non-residential substance use disorder treatment and recovery services to Transition Age Youth, adults and older adults with substance use disorder-induced problems, including co-occurring mental health disorders • Services incorporate evidence-based treatment and recovery service approaches that incorporate both the 12-step models (e.g., AA, NA) and non-12-step models (e.g., SMART Recovery, Rational Recovery, and Secular Organizations for Sobriety). Also, PC 1000 (Deferred Entry of Judgement) drug diversion services to adults	Vista Hill Foundation-Bridges North Central 3148 Midway Drive, Ste. #113, San Diego, CA 92110 (619) 363-0853	4
CSS	TAOA-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Adult	North Coastal Regional Recovery Center	Non-residential substance use disorder treatment and recovery service center for adults 18 years and older with substance use disorder including those who may have a co-occurring mental health disorder	Assist individuals to become and remain free of substance use disorder. For clients with co-occurring disorders, the goal is to ensure that adults experiencing co-occurring substance use disorder and mental health problems receive services that comprehensively address both disorders	Adults 18 years and older with substance use disorder(s), including those who may have co-occurring mental health and substance use	• Evidence-based treatment and recovery services approaches that incorporate both 12-step models (e.g., AA, NA) and non-12 step models (e.g., SMART Recovery, Rational Recovery, Secular Organizations for Sobriety) • Provide PC 1000 (Deferred Entry of Judgment) drug diversion services to adults	McAlister Institute for Treatment and Education 2821 Oceanside Blvd. Oceanside, CA 92054 (760) 721-2781	5
CSS	TAOA-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Adult	South Regional Recovery Center	Non-residential substance use disorder treatment and recovery service center. Incorporating evidence-based treatment and recovery services	Ensure that adults experiencing co-occurring substance use disorder and mental health problems receive services that comprehensively address both disorders, so the individual may achieve a substance use disorder free lifestyle	Adults 18 years and older with substance use disorder, including those who may have co-occurring mental health	• Non-residential substance use disorder treatment and recovery services to Transition Age Youth, adults and older adults with substance use disorder-induced problems, including co-occurring mental health disorders • Services incorporate evidence-based treatment and recovery service approaches that incorporate both 12-step models (e.g., AA, NA) and non-12 step models (e.g., SMART Recovery, Rational Recovery, and Secular Organizations for Sobriety). Also, PC 1000 (Deferred Entry of Judgment) drug diversion services to adults	McAlister Institute for Treatment and Education South Regional Recovery Center 1180 Third Ave., Suite C-3/C4 Chula Vista, CA 91911 (619) 691-8164	1

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	TAOA-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Adult	East Regional Recovery Center	Non-residential substance use disorder treatment and recovery service center for adults 18 years and older with substance use disorder including those who may have a co-occurring mental health disorder	Assist individuals to become and remain free of substance use disorder problems addressing both disorders for adults experiencing co-occurring substance use disorder and mental health problems	Adults 18 years and older with substance use disorder problems, including those who may have co-occurring mental health disorder	• Non-residential substance use disorder treatment rehabilitation services	McAlister Institute for Treatment and Education East Regional Recovery 1365 North Johnson Ave. El Cajon, CA 92020 (619) 440-4801	2
CSS	TAOA-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Adult	North Inland Regional Recovery Center	Non-residential substance use disorder treatment and recovery service center for adults 18 years and older with substance use disorder including those who may have a co-occurring mental health disorder	Ensure that adults experiencing co-occurring substance use disorder and mental health problems receive services that comprehensively address both disorders, so the individual may achieve a substance use disorder free lifestyle	Adults 18 years and older with substance use disorder, including those who may have co-occurring mental health	• Non-residential substance use disorder treatment and recovery services to Transition Age Youth, adults and older adults with substance use disorder-induced problems, including co-occurring mental health disorders • Services incorporate evidence-based treatment and recovery service approaches that incorporate both 12-step models (e.g., AA, NA) and non-12 step models (e.g., SMART Recovery, Rational Recovery, and Secular Organizations for Sobriety.) Also, PC 1000 (Deferred Entry of Judgement) drug diversion services to adults	McAlister Institute for Treatment and Education North Inland Recovery Center 200 East Washington Ave., Suite 100 Escondido, CA 92025 (760) 741-7708	5
CSS	TAOA-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Adult	Substance Use Disorder Recovery Center UPAC	Non-residential substance use disorder treatment and recovery for adults and Transition Age Youth	Support integrated treatment of co-occurring disorder issues for those enrolled in substance use disorder treatment. Reduce stigma associated with mental health concerns and provide additional support or referrals according to needed	Adults 18 years and older who are Asian and Pacific Islander	• Non-residential substance use disorder treatment • Family education	Union of Pan-Asian Communities (UPAC) 3288 El Cajon Blvd., Suites 3, 6, 10, 11, 12 & 13 San Diego, CA 92104 (619) 521-5720	4
CSS	TAOA-SD	Augmented Services Program (ASP)	Carrolls Residential Care, Carrolls Community Care, Anthem Compassionate, Casa El Cajon, Orlando Residential Care and Fancor Guest Home	Augmented Services Program to provide additional therapeutic and support services in licensed residential care facilities	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18 years and older who have a serious mental illness living in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licenses residential care facilities (also known as B&C facilities); Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	Carrolls residential: Bryan Meyers 619-444-3181 and 619-442-8893, Anthem: Charity Bailey 619-303-3717, Casa El Cajon Becky Rayo 619-440-1335, Orlando and Fancor: Cyra Manalot 619-444-9411 and 619-588-1761	All
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Areta Crowell Clinic	Bio-Psychosocial Rehabilitation Wellness Recovery provides outpatient mental health rehabilitation and recovery services, case management; and long term vocational support	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services	Adults 18 years and older who have a serious mental illness including those who may have a co-occurring substance use disorder living in San Diego County	• Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults age 18 years and older who have serious mental illness • Services provided at a Bio-Psychosocial Rehabilitation Wellness Recovery center with Supported Housing	Areta Crowell BPSR Program 1963 4th Ave. San Diego, CA 92101 (619) 233-3432 ext. 1308	1, 4
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Community Wellness Center	Certified Bio-Psychosocial Rehabilitation Wellness Recovery Center that provides outpatient mental health rehabilitation and recovery services, case management; and long-term vocational support	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services	Adult 18 years and older who have a serious mental illness including those who may have a co-occurring substance use disorder living in San Diego County	• Outpatient mental health clinic providing Medi-Cal certified treatment, rehabilitation, and recovery services • This clinic offers walk in service during their normal hours of operation	Community Wellness Clinic 5348 University Ave. Suite #108 San Diego, CA 92108 (619) 255-7550	4
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Douglas Young BPSR Center	North Central Region Adults Region Adults/Older Adults Bio-Psychosocial Rehabilitation Wellness Recovery Center	Increase the number of Transition Age Youth with serious mental illness receiving integrated, culturally specific mental health services countywide	Adults/Older Adults who have a serious mental illness, including those with co-occurring substance use disorder, and Medi-Cal eligible or indigent	• Provides outpatient mental health rehabilitation and recovery services, an urgent walk-in component, case management; and long-term vocational support	Community Research Foundation (CRF) - Douglas Young Clinic 10717 Camino Ruiz, Suite 207 San Diego, CA 92126 (858) 695-2211	3
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Heartland Center	Provides Adults/Older Adults Bio-Psychosocial Rehabilitation clinical outpatient services that integrate mental health services and rehabilitation treatment and recovery service	Provide outpatient mental health services and AB 109 enhanced mental health outpatient services to persons with very serious mental illness	Adults/older adults with a serious mental illness, including those who may have a co-occurring substance use disorder	• Outpatient mental health clinic providing treatment, rehabilitation, and recovery Probation-funded AB 109 component	Community Research Foundation (CRF) East Region Heartland Center 1060 Estes St. El Cajon, CA 92020 (619) 440-5133	2

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Jane Westin Wellness & Recovery Center	Urgent Walk-In Services for Mental Health Evaluation	Provide short-termed services to include mental health evaluation, psychiatric consultation, and linkage in the community to assist clients on their path to recovery	Adults 18 years and older who have serious mental illness including those who may have a co-occurring substance use disorder	• Walk-In access and assessment • Treatment, rehabilitation, and recovery services	Community Research Foundation (CRF) Jane Westin Wellness & Recovery Center 1045 9th Ave San Diego, CA 92101 (619) 235-2600 ext. 201	1, 4
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Alianza Wellness Center	Bio-Psychosocial Rehabilitation Wellness Recovery Center that provides outpatient mental health rehabilitation and recovery services, and case management services.	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge awareness or awareness of available services	Adult/Older Adults individuals who have serious mental illness/co-occurring disorder and are eligible for Medi-Cal or are indigent	• Bio-psychosocial rehabilitation wellness recovery center • Outpatient treatment, case management/brokerage, and peer support • Rehabilitative, recovery, and vocational services and supports	MHS Inc. Alianza Wellness Center 5555 Reservoir Dr. Ste. #204-A San Diego, CA 92120 (619) 822-1800	4
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Project Enable Outpatient Program	Provides a Short-Doyle Medi-Cal certified Bio-Psychosocial Rehabilitation Wellness Recovery Center that provides outpatient mental health rehabilitation and recovery services, an urgent walk-in component, and case management brokerage	Provide outpatient mental health rehabilitation, recovery services, an urgent walk-in component, and case management brokerage	Transition Age Youth, Adults and Older Adults with a serious mental illness, including those who may have a co-occurring substance use disorder; Adults/Older Adults who are low income or Medi-Cal eligible	• Provides outpatient mental health rehabilitation and recovery services, an urgent walk-in component, and case management brokerage	Neighborhood House Association Project Enable 286 Euclid Ave. San Diego, CA 92114 (619) 266-9400	1, 4
CSS	TAOA-SD	Client Liaison Services	Client Liaison Services	Client liaison services aims to increase client participation and involvement in Behavioral Health Services Adult and Older Adult System of Care through peer advocacy	Develop and coordinate increasing client involvement and partnership in the development of policies, practices and programs to ensure client needs are accommodated	Adults 18 years and older who have a serious mental illness and receive services through Behavioral Health Services	• Peer advocacy • Engagement and education	Recovery Innovations, International 3838 Camino del Rio North, Ste. #380 San Diego, CA 92108 (858) 274-4650	All
CSS	TAOA-SD	Client Operated Peer Support Services	Client Operated Peer Support Services	Client-operated peer support services program that includes countywide peer education, peer advocacy, peer counseling, peer support of client-identified goals with referrals to support agencies	Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-.sufficiency	Adults 18 years and older who have a serious mental illness living in San Diego County	• Client-operated peer support services program that includes countywide peer education, peer advocacy, peer counseling, peer support of client-identified goals with referrals to relevant support agencies • Skill development classes to adults with serious mental illness	Recovery Innovations, International 3838 Camino del Rio North, Ste. #380 San Diego, CA 92108 (858) 274-4650	All
CSS	TAOA-SD	Clubhouse	Casa Del Sol Clubhouse (South Region)	Provides mental health-related recovery group counseling, social support services and employment development to members	Provide member-driven clubhouse services to individuals experiencing and/or recovering from serious mental illness	Adults 18 years and older who have a serious mental illness including those who may have a co-occurring substance use disorder living in San Diego County	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	Community Research Foundation (CRF) - South Bay Casa Del Sol Clubhouse 1157 30th St. San Diego, CA 92154 (619) 429-1937	1
CSS	TAOA-SD	Clubhouse	Episcopal Community Services Friend to Friend (F2F) Clubhouse (Central Region)	Provides mental health-related recovery group counseling, social support services and employment development to members. In addition, the clubhouse provides street outreach to engage homeless adults with serious mental illness, including veterans, who may also have co-occurring substance use disorder	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Homeless Adults/Older Adults who have a serious mental illness; Services are in Central Region with an emphasis in downtown San Diego	• Group counseling Social support • Employment and education services • Support access to medical, psychiatric, and other services	National Alliance on Mental Illness (NAMI) San Diego 5095 Murphy Canyon Rd. San Diego, CA 92123 (858) 634-6590	4
CSS	TAOA-SD	Clubhouse	Escondido Clubhouse	Provides mental health-related recovery group counseling, social support services and employment development to members	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Adults 18 years and older who have a serious mental illness living in San Diego County	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	Mental Health Systems, Inc. (MHS) 474 W. Vermont Ave., Suite 105 Escondido, CA 92025 (760) 737-7125	3
CSS	TAOA-SD	Clubhouse	Mariposa Clubhouse (North Coastal Region)	Provides mental health-related recovery group counseling, social support services and employment development to members	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Adults 18 years and older who have a serious mental illness living in San Diego County	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	Mental Health Systems (MHS), Inc. 1701 Mission Ave, Suite 120 Oceanside, CA 92058 (760) 439-2769	5
CSS	TAOA-SD	Clubhouse	Neighborhood House Application Friendship Clubhouse (Central Region)	Provides mental health-related recovery group counseling, social support services and employment development to members	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development or life skills	Adults/Older Adults 18 years and older who have a serious mental illness and who are eligible for Medi-Cal funded services or are indigent, including those with co-occurring substance use disorders	• Provides rehabilitation services • Assist clients to achieve goals in areas such as employment, education, social relationships, recreation, health, and housing, and supports access to medical, psychiatric, and other services	Neighborhood House Association 286 Euclid Ave. San Diego, CA 92114 (619) 266-9400	1, 4
CSS	TAOA-SD	Clubhouse	The Corner Clubhouse - Areta Crowell (Central Region)	Provides mental health-related recovery group counseling, social support services and employment development to members	Increase countywide social and community rehabilitation activities and employment service. Increase client's self-sufficiency through development or life skills	Adults/Older Adults 18 years and older who have a serious mental illness including those with co-occurring substance use disorders	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	Corner Clubhouse 2864 University Ave. San Diego, CA 92104 (619) 683-7423	4

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	TAOA-SD	Clubhouse	The Meeting Place & Warm Line	Provides mental health-related recovery group counseling, social support services and employment development to members. The program also offers a non-crisis phone service seven hours a day, seven days a week that is run by adults for adults who are in recovery from mental illness clubhouse also offers social security income advocates and peer support line	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills. The aim of the program is for the support line to be an essential support service for persons recovering from mental illness	Underserved Adults/Older Adults 18 years and older with a serous mental illness including those who may have a co-occurring substance use disorder	• Provides rehabilitative, recovery, health and vocational services and supports	The Meeting Place 2553 State St. San Diego, CA 92103 (619) 294-9582	4
CSS	TAOA-SD	Clubhouse	Visions Clubhouse (South Region)	Provides mental health-related recovery group counseling, social support services and employment development to members	Provide member-driven clubhouse services to individuals experiencing and/or recovering from serious mental illness	Adults 18 years and older who have a serious mental illness including those who may have a co-occurring substance use disorder and reside in San Diego County	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	Mental Health Association Visions Clubhouse 226 Church Ave. Chula Vista, CA 91911 (619) 420-8603	1
CSS	TAOA-SD	Clubhouse	Oasis Clubhouse	To provide mental health-related recovery group counseling, social support services and employment development to transition age youth members	Member-driven center that assists to achieve goals in areas such as employment, education, social relationships, recreation, health, and housing, and supports access to medical, psychiatric, and other services	Transition Age Youth 16 to 25 years old diagnosed with a serious mental illness who may have a co-occurring substance use disorder	• Provides clubhouse services to transition age youth 16 to 25 years old diagnosed with a serious mental illness who may have a co-occurring substance use disorder	Pathways Community Services 3330 Market St. #C San Diego, CA 92102 (858) 300-0470	All
CSS	TAOA-SD	Clubhouse	East Region Clubhouse	Provides mental health-related recovery group counseling, social support services and employment development to members	Provide member-driven clubhouse services to individuals experiencing and/or recovering from serous mental illness	Adults 18 years and older who have a serious mental illness living in San Diego County	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	East Corner Clubhouse 1060 Estes St., #104 El Cajon, CA 92020 (619) 631-0441	2
CSS	TAOA-SD	Clubhouse	BPSR Center (Mid City) BPSR Center (Serra Mesa) EAST WIND	Provides outpatient, case management brokerage, clubhouse and vocational support services	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Monolingual and/or limited English proficient Asian/Pacific Islander adults who have a serious mental illness	• Case management • Mobile outreach • Long-term vocational services, outpatient mental health rehabilitation; recovery services	Union of Pan Asian Communities (UPAC) - Mid City 5348 University Ave., Suites 101 & 120 San Diego, CA 92105 (619) 229-2999 UPAC Serra Mesa 8745 Aero Dr., Suite 330 San Diego, CA 92123 (858) 268-4933	4
CSS	TAOA-SD	Crisis Stabilization - North Inland	Crisis Stabilization Unit	Crisis Stabilization Unit in the North Inland Region for San Diego County residents who are experiencing a psychiatric emergency, which may also include co-morbid substance use disorder problems	Impact unnecessary and lengthy involuntary inpatient treatment, as well as to promote care in voluntary recovery oriented treatment settings	Voluntary and involuntary adults with a serious mental illness	• Provide a twenty-four hour, seven days a week hospital-based Crisis Stabilization Unit (CSU) for adult and older adult Medi-Cal beneficiaries.	Palomar Health 555 E. Valley Pkwy. Escondido, CA 92025 (760) 739-3000	3, 5
CSS	TAOA-SD	Crisis Stabilization - South	Bayview Crisis Stabilization Unit	South Region 24-hour hospital based crisis stabilization unit for Adults who are experiencing a psychiatric emergency.	Impact unnecessary and lengthy involuntary impatient treatment, as well as promote care in voluntary recovery oriented treatment settings.	Voluntary and involuntary adults and older adults with a serious mental illness.	• 24-hour, seven days a week, hospital-based crisis stabilization as an alternative to emergency room services. • Behavioral Health Assessments • Medication management • Case management • Linkage to community services	Prime Health Paradise Valley Bayview Crisis Stabilization Unit 330 Moss Street Chula Vista, Ca. 91911 (619) 426-6310	1
CSS	TAOA-SD	Crisis Stabilization Services-North Coastal	Crisis Stabilization Unit	Provide 24/7 crisis stabilization services to individuals experiencing a psychiatric emergency	Reducing the severity of a person's level of distress and/or need for a higher level of care	Transition Age Youth, Adults/Older Adults who have serious mental illness, including those who may have a co-occurring substance use disorder	Crisis stabilization services	TBD	5
CSS	TAOA-SD	Faith Based Services	Health & Wellness In-Reach Ministry	Provides in-reach, engagement; education; peer support; follow- up after release from detention facilities and linkages to services that improve participant's quality of life. The Faith-Based Wellness and Mental Health In-Reach Ministry will provide support services consistent with pastoral counseling and the individual's faith in addition to information, linkage and education about community-based resources.	Reduce recidivism, diminish impact of untreated health, mental health and/or substance use issues, prepare for re-entry into the community, and ensure successful linkage between in-jail programs and the community aftercare program that support former incarcerated youth and adults	At-risk African-American and Latino adults (1170/re-alignment population) or Transition Age Youth incarcerated at designated facilities, with an additional focus on inmates with serious mental illness	• Program provides discharge planning and short-term transition services for clients who are incarcerated and identified to have a serious mental illness to assist in connecting clients with community-based treatment once released	Neighborhood House Association Project In-Reach 286 Euclid Ave., Suite 102 San Diego, CA 92114 (619) 266-9400	All

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	TAOA-SD	Home Finder	Home Finder	Housing navigation and support for designated BHS adult clinics	Support for clients experiencing homelessness enrolled in BHS designated outpatient MH clinics. Services include housing navigation and tenant support services	Adults 18 years and older with serious mental illness who are experiencing homelessness in the city of San Diego	• Support identifying and securing safe and affordable housing (both single and shared occupancy). • Create and update a centralized hub for housing resources and roommate matching services • Provides flex funds to support resident retention. • Housing resources and education to clients, staff, and landlords regarding affordable housing for people with serious mental illness	Alpha Project 2667 Camino Del Rio South, Ste 113 San Diego, CA 92108 (619) 542-1877	1, 3, 4
CSS	TAOA-SD	In-Home Outreach Teams (IHOT)	In-Home Outreach Team IHOT - North Inland, North Central	Mobile In-Home Outreach Team for serious mental illness	Reduce the effects of untreated mental illness in individuals with serious mental illness and their families, and to increase family member satisfaction with the mental health system of care	Adults/Older Adults reluctant to seek treatment.	• In-Home Mobile Outreach	Mental Health Systems - IHOT 365 Rancho Santa Fe Rd., Suite 100 San Marco, CA 92078 (760) 591-0100	5
CSS	TAOA-SD	In-Home Outreach Teams (IHOT)	In-Home Outreach Team IHOT Central/East/ South	Mobile In-Home Outreach Teams for a serious mental illness	Reduce the effects of untreated mental illness in individuals with serious mental illness and their families, and to increase family member satisfaction with the mental health system of care	Adults/Older Adults reluctant to seek treatment	• In-Home Mobile Outreach	Telecare Corporation - IHOT 1080 Marina Village Pkwy,. Suite 100 Alameda, CA 94501 (619) 961-2120	1, 2, 4
CSS	TAOA-SD	In-Home Outreach Teams (IHOT)	UCSD-IHOT/AOT Evaluation	Consultant conducts outcome and program evaluation of In-Home Outreach Teams (IHOT) and Assisted Outpatient Treatment (AOT) services by: a) conducts client, family and staff focus groups; b) evaluates program and outcome data; and c) prepares and submits to County periodic and final reports of findings and recommendations for potential future system-wide implementation.	Consultant conducts outcome and program evaluation of In-Home Outreach Teams (IHOT) and Assisted Outpatient Treatment (AOT) services	N/A	Evaluation Services	Regents of the University of California San Diego 9500 Gilman Drive La Jolla, CA	All
CSS	TAOA-SD	Inpatient and Residential Advocacy Services	Patient Advocacy Services	Patient Advocacy Services for mental health clients will be expanded to County-Identified Skilled Nursing Facilities	Provide on-going support/advocacy services and training to staff and residents at County-identified Board and Care facilities. Expands services for County-Appointed Patient Advocate	Children, Transition Age Youth, Adults/Older Adults	• Provides inpatient advocacy services for adults and children/adolescents receiving mental health services in any covered 24-hour facility • Provides client representation at legal proceedings where denial of client rights are concerned • Handles client complaints and grievances for clients in these facilities	Jewish Family Service 8788 Balboa Ave. San Diego, CA 92123 (619) 282-1134	All
CSS	TAOA-SD	Behavioral Health Assessors	Neighborhood House Association (Project Enable)	Bio-Psychosocial Rehabilitation Wellness Recovery provides outpatient mental health rehabilitation and recovery services, case management; and long term vocational support	Provide transitional services to support youth to be released from detention	At risk African-American and Latino citizens who are incarcerated adults or Transition Age Youth at designated detention facilities and will be released in San Diego County	• Advocacy, assessment, engagement, and resource connection	Neighborhood House Association 5660 Copley Dr. San Diego, CA 92114 (619) 244-8241	All
CSS	TAOA-SD	Justice System Discharge Planning	Project In-Reach (aka Project Enable)	Provides in-reach, engagement; education; peer support; follow- up after release from detention facilities and linkages to services that improve participant's quality of life	Reduce recidivism, diminish impact of untreated health, mental health and/or substance use issues, prepare for re-entry into the community, and ensure successful linkage between in-jail programs and the community aftercare program that support former incarcerated youth and adults	At-risk African-American and Latino adults (1170/re-alignment population) or Transition Age Youth incarcerated at designated facilities, with an additional focus on inmates with serious mental illness	• Program provides discharge planning and short-term transition services for clients who are incarcerated and identified to have a serious mental illness to assist in connecting clients with community-based treatment once released	Neighborhood House Association Project In-Reach 286 Euclid Ave., Suite 102 San Diego, CA 92114 (619) 266-9400	All

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	TAOA-SD	North Inland Mental Health Center	North Inland Mental Health Center	Outpatient mental health and rehabilitation and recovery, crisis walk in, peer support, homeless outreach, case management and long term vocational support	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services	Adults 18 years and older	• Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults 18 years and older who have serious mental illness, including those who may have a co-occurring substance use disorder	Mental Health Systems, Inc. (MHS) 125 W. Mission Escondido, CA 92025 (760) 747-3424 MHS Kinesis North WRC 474 W. Vermont Escondido, CA 92025 (760) 480-2255 Kinesis North WRC--Ramona 1521 Main St. Ramona, CA 92065 (760) 736-2429 MHS-WRC with MHSA and Satellite North Inland 474 West Vermont Suite 101 Escondido, CA 92025 (760) 480-2255	3
CSS	TAOA-SD	Peer Assisted Support Services	TBD	A culturally competent, recovery-focused Peer Assisted Support Services program for adults with serious mental illness who are not connected to County operated or Contracted Behavioral Health Services and present at Behavioral Health Units or Crisis Residential programs in the Central region. The Peer Assisted Support Services program engages with individuals in inpatient or crisis residential programs and continues engagement with these individuals after discharge from these programs to ensure they are connected to Behavioral Health Services (BHS). The Peer Assisted Support Services program will provide linkages and a warm handoff to needed mental health, substance use, and social services with the goal of decreasing hospitalization and crisis residential acute care by increasing connections to ongoing behavioral health services. The designated 24/7 programs in the Central Region are: Scripps Mercy and University of California San Diego (UCSD) Behavioral Health Units, and in their Emergency Departments (ED), as well as County designated Crisis Residential facilities.	The goal of the Peer Assisted Support Services project is to increase the depth and breadth of services to persons diagnosed with serious mental illness who use acute, crisis-oriented mental health services but are unconnected with Mental Health services, Substance Use Disorder services or community resources through the provision of peer specialist coaching incorporating shared decision-making and active social supports.	Transition Age Youth, Adults/Older Adults with serious mental illness. Adults diagnosed with a serious SMI, including co-occurring Substance Use Disorder and are not currently connected to County Operated Outpatient Clinics or contracted mental health or substance use programs and who are present at the designated 24/7 programs in the Central Region: Scripps Mercy and University of California San Diego (UCSD) Behavioral Health Units, and in their Emergency Departments (ED), as well as County designated Crisis Residential facilities.	• Peer specialist coaching • Connecting participants to relevant services	National Alliance on Mental Illness (NAMI), San Diego 5095 Murphy Canyon Rd., Suite 320 San Diego, CA 92123 (858) 634-6586	4
CSS	TAOA-SD	Public Defender - Behavioral Health Assessor	Public Defender Discharge	Licensed mental health clinicians will provide discharge planning, care coordination, referral and linkage, and short term case management to persons with a serious mental illness who have been referred by the Court for services	Public Defender Treatment Unit will reduce untreated mental illness by ensuring persons are connected to system of care	Adults 18 years and older with a serious mental illness who are incarcerated or Transition Age Youth at designated detention facilities who will be released in San Diego County	• Discharge planning • Care coordination • Referral and linkage • Short term case management	Public Defender 450 B St., Ste 1100 San Diego, CA 92101	All
CSS	TAOA-SD	San Diego Employment Solutions	San Diego Employment Solutions	Supported employment services and opportunities for Transition Age Youth, Adults and Older Adults with serious mental illness	Increase competitive employment of adults 18 and older who have a serious mental illness and who want to become competitively employed	Adults 18 years and older who have a serious mental illness and need assistance with employment	• Supportive employment program that provides an array of job opportunities to help adults with serious mental illness obtain competitive employment • Use a comprehensive approach that is community-based, client and family-driven, and culturally competent	Mental Health Systems, Inc. (MHS) Employment Solutions 10981 San Diego Mission Rd. # 100 San Diego, CA 92108 (619) 521-9569	All
CSS	TAOA-SD	San Diego Housing Commission	Housing Subsidy program	Administrative support for 100 San Diego Housing Commission subsidies	Provide support for housing	Adults 18 years and older who have a serious mental illness and are experiencing homelessness in the city of San Diego.	• Housing Vouchers/subsidies	San Diego Housing Commission 1122 Broadway San Diego, CA 92101 (619) 231-9400	1, 3, 4

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	TAOA-SD	Short Term Acute Residential Treatment (START)	START Vista Balboa, New Vistas, Halcyon, Crisis Center, Turning Point, Jary Barreto, Isis Crisis Center	Provide crisis residential services to individuals with serious mental illness and may have co-occurring substance use disorder	Provide urgent services in North Coastal, Central, East and South Regions of San Diego to meet the community-identified needs	Voluntary adults 18 years and older who may have a serious mental illness and who may have a co-occurring substance use disorder that are experiencing a mental health crisis, in need of intensive, non-hospital intervention and are residents of San Diego County	• Twenty-Four hour, seven days a week crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital	Community Research Foundation (CRF) Vista Balboa (619) 233-4399 CRF New Vistas Crisis Center (619) 239-4663 CRF Halcyon Crisis Center (619) 579-8685 CRF Turning Point (760) 439-2800 CRF Jary Barreto Crisis Center (619) 232-4357 CRF Del Sur Crisis Center (619) 575-4687	All
CSS	TAOA-SD	Short-Term Bridge Housing	United Homes	Short-term & Bridge Housing for adults with serious mental illness who are experiencing homelessness	Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Adults, aged 18 and above, who have a serious mental illness, and who may have a co-occurring substance use disorder, who are experiencing homelessness	• Shelter and food in a residential setting that has staff available during all operating hours • Safe and sanitary quarters on a nightly basis • Coordinate Peer Support Services	United Homes 336 South Horne St. Oceanside, CA 92054 (760) 612-5980	3, 5
CSS	TAOA-SD	Short-Term Bridge Housing	Rooted Life	Short-term & Bridge Housing for adults with serious mental illness who are experiencing homelessness	Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Adults, aged 18 and above, who have a serious mental illness, and who may have a co-occurring substance use disorder, who are experiencing homelessness	• Shelter and food in a residential setting that has staff available during all operating hours • Safe and sanitary quarters on a nightly basis • Coordinate Peer Support Services	Rooted Life 864 Grand Avenue, Suite 802 San Diego, CA 92109 (619) 357-6472	2
CSS	TAOA-SD	Short-Term Bridge Housing	Interfaith Community Services	Short-term & Bridge Housing for adults with serious mental illness who are experiencing homelessness	Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Adults, aged 18 and above, who have a serious mental illness, and who may have a co-occurring substance use disorder, who are experiencing homelessness	• Shelter and food in a residential setting that has staff available during all operating hours • Safe and sanitary quarters on a nightly basis • Coordinate Peer Support Services	Interfaith Community Services 550 W. Washington St., Suite B Escondido, CA 92025 (760) 489-6380	3, 5
CSS	TAOA-SD	Short-Term Bridge Housing	Ruby's House Independent Living	Short-term & Bridge Housing for adults with serious mental illness who are experiencing homelessness	Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Adults, aged 18 and above, who have a serious mental illness, and who may have a co-occurring substance use disorder, who are experiencing homelessness	• Shelter and food in a residential setting that has staff available during all operating hours • Safe and sanitary quarters on a nightly basis • Coordinate Peer Support Services	Ruby's House Independent Living Facility 1702 Republic St. San Diego, CA 92114 (619) 756-7211	4
CSS	TAOA-SD	Short-Term Bridge Housing	Urban Street Angels (Transitional Shelter Beds for Transition Age Youth)	Short-term & Bridge Housing for Transitional Age Youth (TAY) with serious mental illness or serious emotional disturbance who are experiencing homelessness	The provision of housing and support services to TAY with serious mental illness or serious emotional disturbance, by providing accessible Short-term and Bridge Housing beds for identified clients	Transitional Age Youth, 18 to 24 years of age, who have a serious emotional disturbance or a serious mental illness, and who may have a co-occurring substance use disorder, who are experiencing homelessness	• Emergency shelter and transitional beds • Case Management	Urban Street Angels, Inc. 1404 Fifth Ave San Diego, CA 92101 (619) 415-6616	4
CSS	TAOA-SD	Tenant Peer Support Services	Alpha Project for the Homeless	Housing navigation and support for designated BHS adult clinics	On-going support for clients experiencing homelessness enrolled in BHS designated outpatient MH clinics. Services include housing navigation and tenant support services.	Adults 18 years and older with serious mental illness who are experiencing homelessness.	• Support identifying and securing safe and affordable housing • Provides flex funds to support resident retention. • Housing resources and education to clients, staff, and landlords regarding affordable housing for people with serious mental illness	Alpha Project 2667 Camino Del Rio South, Suite 204 San Diego, CA 92108 (619) 542-1877	1, 2, 3, 5
CSS	TAOA-SD	Walk-In Assessment Center	North County Walk in Assessment Center and Crisis Stabilization Unit	• Provide walk-in services assessment and referral services to individuals experiencing a mental health episode • Provide Telepsych Hub Telemedicine services on an on-demand basis • Provide 24/7 crisis stabilization services to individuals experiencing a psychiatric emergency	• Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services • Outpatient psychiatric prescriber services for children, and adult mental health consumers utilizing Telehealth practices and technology • Reducing the severity of a person's level of distress and/or need for a higher level of care	• WIAC and CSU: Transition Age Youth, Adults/Older Adults who have serious mental illness, including those who may have a co-occurring substance use disorder • Telehealth: all ages	• Walk-in treatment center Rehabilitation and recovery services • Telehealth prescriber services • Crisis stabilization services	Exodus Recovery, Inc. North County Walk in Assessment Center 1520 South Escondido Blvd. Escondido, CA 92025 (760) 871-2020 Vista Walk In Assessment Center 524 W. Vista Way Vista, CA 92083 (760) 758-1150	3, 5

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	TAOA-SD/CY-SD	Family Mental Health Education and Support	Family Mental Health Education and Support	Provides a series of educational classes presented by family members using and established family education curriculum to provide education and support to persons who have relatives (or close friends) with mental illness	Promote integration of family education services. Increase family involvement coping skills and improve supportive relationships	Family members and friends of persons who have a serious mental illness	• Provides a series of educational classes presented primarily by family members or persons with serious mental illness using and established family education curriculum to provide education and support to persons who have relatives or close friends with mental illness • Increase family members coping skills and support increased involvement ad partnership with the mental health system	National Alliance on Mental Illness (NAMI) San Diego 5095 Murphy Canyon Rd. San Diego, CA 92123 (858) 634-6590	All
CSS	TAOA-SD/CY-SD	Supplemental Security Income (SSI) Advocacy Services	Supplemental Security Income (SSI) Advocacy Services	Supplemental Security Income Advocacy services. Responsible for the submission of applications to the Social Security Administration and further follow-up as needed	Expedite awards, provide training and consultation to designated Clubhouse advocates, and provide outreach and education to child focused programs	Consumers who are recipients of General Relief, Cash Assistance Program for Indigents, County Medical Services and mental health consumers (children and adults) of BHS	• Supplemental Security Income Advocacy • Collaborative advocacy with designated Clubhouse staff • Outreach, education, consultations • Application processing	Legal Aid 110 South Euclid Ave. San Diego, CA 92114 (877) 734-3528	All
PEI	CO-03	Integrated Peer & Family Engagement Program	Next Steps	Provides comprehensive, peer-based care coordination, brief treatment and system navigation to adults with mental health and/or substance use disorders. Services aim to engage clients by linking them to appropriate treatment and support services spanning the entire continuum of care, including behavioral health and primary care clinics to reduce the need for hospitalizations.	The program assists participants with increases resiliency and self-care, reduced consumption of alcohol and drugs, improved medication adherence, decreased depression and anxiety, reduced problems commonly associated with SUD, and improved mental and physical wellness. The program also links to participants to treatment and other community resources as needed.	Adults 18 years and older	• Walk-in center and services in community clinics and SDCPH • Screening, brief treatment, and referrals and linkages to resources and services in the community	National Alliance on Mental Illness (NAMI), San Diego 5095 Murphy Canyon Rd., Suite 320 San Diego, CA 92123 (858) 643-6580	All
PEI	DV-03	Community Violence Services - Alliance for Community Empowerment	Alliance for Community Empowerment	Provides trauma informed, community centered, family driven and evidenced based Community Violence Response services, support, referrals and linkages to care countywide	Increase in resilience; increased knowledge of services; increased problem-solving and coping skills; reduces stigma and suicidal risk factors; reduces psycho-social impact of trauma	Community members including middle-school age youth boys and girls affected by community violence	• Immediate support and assistance, referrals and linkages to care after an incidence of community violence. • Grief counseling, individual, and group interventions • Outreach, engagement, community education	Union of Pan Asian Communities (UPAC) 5348 University Ave., Suites 101 and 102 San Diego, CA 92105 (619) 232-6454	All
PEI	DV-04	Community Services for Families - Child Welfare Services	CSF - North Coastal/North Inland	Provides family preservation, family support, and family reunification services to children and families in the CWS system	Provides family preservation, family support, and family reunification services to children and families in the CWS system	Children 0 to 17 years old and their families at a high risk of child abuse and neglect	• Case management • In-Home Parent Education • Safe Care • Systematic Training for Effective Parenting • Parent Partners	North County Lifeline 707 Oceanside Blvd. Oceanside, CA 92054 (760) 842-6250	3, 5
PEI	DV-04	Community Services for Families - Child Welfare Services	CSF - South Region	Provides family preservation, family support, and family reunification services to children and families in the CWS system	Establish a community safety net to ensure the safety and well being of children and their families	Children 0 to 17 years old and their families at a high risk of child abuse and neglect	• Case management • In-home parent education • Safe Care • Systematic Training for Effective Parenting • Parent Partners	South Bay Community Services 430 F St. Chula Vista, CA 91910 (619) 420-3620	1
PEI	DV-04	Community Services for Families - Child Welfare Services	CSF Central & North Central Regions	Provides family preservation, family support, and family reunification services to children and families in the CWS system	Establish a community safety net to ensure the safety and well being of children and their families	Children 0 to 17 years old and their families at a high risk of child abuse and neglect	• Case management • In-Home Parent Education • Safe Care • Systematic Training for Effective Parenting • Parent Partners	Social Advocates for Youth 8755 Aero Dr., Suite 100 San Diego, CA 92123 (858) 565-4148	4
PEI	DV-04	Community Services for Families - Child Welfare Services	CSF East Region	Provides family preservation, family support, and family reunification services to children and families in the CWS system	Establish a community safety net to ensure the safety and well being of children and their families	Children 0 to 17 years old and their families at a high risk of child abuse and neglect	• Case management • In-Home Parent Education • Safe Care • Systematic Training for Effective Parenting • Parent Partners	Home Start 5005 Texas St., Suite 203 San Diego, CA 92108 (619) 629-0727	2
PEI	EC-01	Positive Parenting Program (Triple P)	Positive Parenting Program (Triple P)	Provides mental health prevention and early intervention services for parents using the Positive Parenting Program (Triple P) education curriculum	Specialized culturally and developmentally appropriate mental health PEI services to promote social and emotional wellness for children and their families	Countywide parents and families; parents and guardians of children enrolled in Head Start, Early Head Start, elementary school and community center locations	• Free parenting workshops • Early intervention services • Referrals and linkage	Jewish Family Service 8804 Balboa Ave. San Diego, CA 92123 (858) 637-3000 ext. 3006	All
PEI	FB-01	Early Psychosis Evaluation and Learning Health Care Network	Kickstart	Provides Prevention and Early Intervention (PEI) services for persons who have emerging 'prodromal' symptoms of psychosis	Reduce incidence and severity of mental illness and increase awareness and usage of services	Countywide youth 10 to 25 years old in San Diego County and their families & substantial public component on psychosis	• Prevention through public education • Early intervention, through screening potentially at risk youth • Intensive treatment for youth who are identified as at-risk and their families	Pathways of California Kickstart Program 6160 Mission Gorge Rd., Suite 100 San Diego, CA 92120 (858) 637-3030	All

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
PEI	NA-01	Native American Prevention and Early Intervention	Indian Health Council, Inc.	Provides PEI and substance use disorder prevention and treatment services for Native Americans	Increase community involvement and education through services designed and delivered by Native American communities	American Indians; Alaska Natives; tribal members of South and East Region tribes; and qualified family members residing on reservations; All age groups; North Regions of San Diego County.	• Prevention and early intervention and substance use disorder treatment services • Child abuse prevention case management to Native Americans in North County	Indian Health Council 50100 Golsh Rd. Valley Center, CA 92082 (760) 749-1410	5
PEI	NA-01	Native American Prevention and Early Intervention	San Diego American Indian Health Center	Provides PEI services for Native American Indian/Alaska Native urban youth	Increase community involvement and education through services designed and delivered by Native American communities	At risk and high risk urban American Indian and Alaska Natives children and Transitional Age Youth	• Specialized culturally appropriate prevention and early intervention services to Native American Indian/Alaska Native urban youth and their families who are participants at the Youth Center	San Diego American Indian Health Center 2602 1st Ave., Ste. 105 San Diego, CA 92103 (619) 234-1525	4
PEI	NA-01	Native American Prevention and Early Intervention	Southern Indian Health Council, Inc.	Provides PEI and substance use disorder prevention and treatment services for Native Americans	Increase community involvement and education through services designed and delivered by Native American communities	American Indians; Alaska Natives; tribal members of South and East Region tribes; and qualified family members residing on reservations; All age groups; South and East regions of San Diego County	• Prevention and early intervention and substance use disorder treatment services • Child abuse prevention case management to Native Americans in South and East County	Southern Indian Health Council, Inc. 4058 Willows Rd. Alpine, CA 91901 (619) 445-1188	2
PEI	OA-01	Elder Multicultural Access & Support Services (EMASS)	Elder Multicultural Access & Support Services (EMASS)	Provides outreach and support to older adults, especially non-Caucasian/non-English speaking	Reduce ethnic disparities in service access and use. Increases access to care	Multicultural Seniors, refugees, 60 years and older who are at risk of developing mental health problems	• Outreach and education • Referral and linkage • Benefits advocacy • Peer counseling • Transportation services • Home and community based services	Union of Pan Asian Communities (UPAC) 1031 25th St. San Diego, CA 92102 (619) 238-1783 ext. 30	All
PEI	OA-02	Home Based Services - For Older Adults	Positive Solutions	Provides outreach, and prevention and early intervention services for homebound and socially isolated older adults by using Program to Encourage Active and Rewarding Lives (PEARLS) model	Increase knowledge of signs/symptoms of depression and suicide risk for those who live/work with older adults. Reduces stigma associated with mental health concerns and disparities in access to services	Homebound older adults 60 years and older who are at risk for depression or suicide	• Screening • Assessment • Brief intervention (PEARLS and/or Psycho-education) • Referral and linkage • Follow-up care	Union of Pan Asian Communities (UPAC) 1031 25th St. San Diego, CA 92102 (619) 238-1783 ext. 30	1, 4, 5
PEI	OA-06	Caregiver Support for Alzheimer & Dementia Patients	Caregivers of Alzheimer's Disease and Other Dementia Clients Support Services	Provides caregiver education, training, and early intervention services to prevent or decrease symptoms of depression and other mental health issues among caregivers	Reduce incidence of mental health concerns in caregivers of patients that have Alzheimer's and other types of dementia. Improve the quality of well-being for caregivers and families. Provides services to an underserved/unserved population	Adult Caregivers 18 years and older	• Outreach • Information dissemination • Early intervention • Prevention Education	Southern Caregiver Resource Center 3675 Ruffin Rd. San Diego, CA 92123 (858) 268-4432	All
PEI	PS-01	Father 2 Child	Father 2 Child	Provide outreach and parenting education, improve father, dad, caregiver and child emotional support, communication and parenting interaction	Improve interpersonal communication, reduction in individual and father and child dysfunction, improved employment and career for father and dad.	Fathers, dads, caregivers of children under 17 years of age	• Outreach • Prevention Education	Mental Health America of San Diego County 4069 30th St. San Diego, CA 92104 (619) 543-0412	4
PEI	PS-01	Breaking Down Barriers (BDB) Initiative	Breaking Down Barriers	Outreach, engagement and community organizing across all communities to reduce the stigma associated with mental illness and improve mental health well-being	Reduce mental health stigma to culturally diverse, unserved and underserved populations	Unserved and underserved populations; Latino; Native American; African; Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ); African-American	• Outreach and education to reduce mental health stigma to culturally diverse, unserved and underserved populations • Collaboration with community based organizations to identify and utilize "cultural brokers" in community of color and non-ethnic groups	Jewish Family Services of San Diego 8804 Balboa Ave San Diego., CA 92123 (858) 637-3000	All
PEI	PS-01	Family Peer Support Program	Family Peer Support Program (In Our Own Voice & Friends in the Lobby)	Provides an educational series, where community speakers share their personal stories about living with mental illness and achieving recovery. Written information on mental health and resources will be provided to families and friends whose loved one is hospitalized with a mental health issue	Provide support and increase knowledge of mental illness and related issues. Reduces stigma and harmful outcomes	Family members and friends of psychiatric inpatients	• Resources and support to family and friends visiting loved ones in psychiatric inpatient units in San Diego area • Public education	National Alliance on Mental Illness (NAMI), San Diego 5095 Murphy Canyon Rd., Suite 320 San Diego, CA 92123 (858) 643-6580	All
PEI	PS-01	Mental Health First Aid	Mental Health First Aid	Mental Health First Aid is a public education program designed to give residents the skills to help someone who is developing a mental health problem or experiencing a mental health crisis	Provide county-wide community-based mental health literacy education and training services	Adults/Older Adults who work with youth	• Interactive class that teaches participants how to identify, understand and respond to signs of mental illnesses and substance use disorders	Mental Health America of San Diego County 4069 30th St. San Diego, CA 92104 (619) 543-0412	All
PEI	PS-01	Suicide Prevention & Stigma Reduction Media Campaign - It's Up To Us	Suicide Prevention & Stigma Reduction Media Campaign	Countywide media campaign geared towards suicide prevention and stigma discrimination, a suicide prevention action council to increase public awareness	Prevent suicide and reduce stigma and discrimination experienced by individuals with mental illness and their families. Increases awareness of available mental health services	Countywide individuals with mental illness; families of individuals with mental illness; general public	• Public media campaign to education and promote mental health awareness • Print, radio, and TV ads • Printed materials	Rescue Agency Public Benefit, LLC 2437 Morena Blvd San Diego, CA 92110 (619) 231-7555	All

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
PEI	PS-01	Suicide Prevention Action Plan	Suicide Prevention Action Plan	Provides facilitation of the San Diego Suicide Prevention Council to increase public awareness and understanding of suicide prevention strategies.	Reduce the number of suicides in San Diego County. Provide support and increase knowledge of mental illness and related issues. Reduces stigma and harmful outcomes.	General population, mental health service consumers, local planners, and mental health organizations.	• Suicide prevention action plan for understanding and awareness • Implement prevention initiatives • Facilitate Suicide Prevention Council and workgroups	Community Health Improvement Partners 5095 Murphy Canyon Rd., Suite 105 San Diego, CA 92123 (858) 609-7974	All
PEI	PS-01	Supported Employment Technical Consultant Services	Supported Employment Technical Consultant Services	Provides technical expertise and consultation on county-wide employment development, partnership, engagement, and funding opportunities for adults with serious mental illness. Services are coordinated and integrated through BHS to develop new employment resources	Supported Employment TA will develop 5-Year Strategic Plan and implement strategies within BHS programs that include Supported Employment. TA will also operate as sub-committee of the BHS Adult Council.	Service providers, employers, agencies, government organizations, and other stakeholders	• Promote employment opportunities for adults with serious mental illness	San Diego Workforce Partnership, Inc. 9246 Lightwave Ave. #210 San Diego, CA 92123 (619) 228-2900	All
PEI	RC-01	Rural Integrated Behavioral Health and Primary Care Services	Integrated Behavioral Health and Primary Care Services in Rural Communities	Provides Rural Integrated Behavioral Health and Primary Care Services for prevention and early intervention services. Program works in partnerships with various primary care clinics in rural areas and utilizes a Screening, Brief Intervention and Referral to Treatment (SBIRT) model to identify persons at risk for behavioral health issues. Treatment services are strengths-based, time limited and embrace the concepts of resilience and recovery for adults and children with severe emotional disturbance (SED), and their families.	Program staff provide health education and community engagement events, brief behavioral health interventions, psychiatric consultations, case management services, wellness screenings and referrals to treatment.	Children, Transition Age Youth, Adults/Older Adults	• Assessment • Brief intervention • Education • Mobile outreach	Vista Hill Foundation 1012 Main Street, #101 Ramona, CA (760) 788-9725	All
PEI	RE-01	Independent Living Association (ILA)	CHIP Independent Living Association (ILA)	Creates an Independent Living Association with voluntary membership	Promote the highest quality home environments for adults with severe mental illness and other disabling health conditions. Serve residents that do not need medication oversight, are able to function without supervision, and live independently	Member operators, individuals, families, discharge planners and care coordination who are seeking quality housing resources countywide	• Education and training to member operators and residents. • Website listings • Resources to support clients • Resources to develop their business • Marketing tools • Advocacy support	Community Health Improvement Partners 5059 Murphy Canyon Rd., Suite 105 San Diego, CA 92123 (858) 609-7974	All
PEI	SA-01	School Based Prevention and Early Intervention	Vista Hill - School Based PEI North Inland	Early intervention services utilizing a family focused approach and evidenced based curriculum to provide social-emotional groups to parents and children as well as identified classrooms in designated public schools	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated public schools	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	Vista Hill Foundation 1029 N. Broadway Escondido, CA 92026 (760) 489-4126	5
PEI	SA-01	School Based Prevention and Early Intervention	South Bay Community Services - School Based PEI South	Early intervention services utilizing a family focused approach and evidenced based curriculum to provide social-emotional groups to parents and children as well as identified classrooms in designated public schools	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated public schools	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	South Bay Community Services 430 F St. Chula Vista, CA 91910 (619) 420-3620	1
PEI	SA-01	School Based Prevention and Early Intervention	Palomar Family Counseling - School Based PEI North Coastal Region	Early intervention services utilizing a family focused approach and evidenced based curriculum to provide social-emotional groups to parents and children as well as identified classrooms in designated public schools	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated public schools	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	Palomar Family Counseling Services 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660	3
PEI	SA-01	School Based Prevention and Early Intervention	San Diego Unified School District - School Based PEI Central and North Central	Early intervention services utilizing a family focused approach and evidenced based curriculum to provide social-emotional groups to parents and children as well as identified classrooms in designated public schools	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated public schools	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	San Diego Unified School District 4487 Oregon St. San Diego, CA 92116 (619) 362-4300	3, 4
PEI	SA-01	School Based Prevention and Early Intervention	San Diego Unified School District - School Based PEI Central and Southeastern	Early intervention services utilizing a family focused approach and evidenced based curriculum to provide social-emotional groups to parents and children as well as identified classrooms in designated public schools	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated public schools	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	San Diego Unified School District 4487 Oregon St. San Diego, CA 92116 (619) 362-4301	4
PEI	SA-01	School Based Prevention and Early Intervention	San Diego Youth Services - School Based PEI East	Early intervention services utilizing a family focused approach and evidenced based curriculum to provide social-emotional groups to parents and children as well as identified classrooms in designated public schools	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated public schools. Refugee children pre-school through 3rd grade who struggle with transitioning and would benefit from small groups	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement • Assimilation groups for refugee children/parents.	San Diego Youth Services 3845 Spring Dr. Spring Valley, CA 91977 (619) 258-6877	2
PEI	SA-02	School Based Suicide Prevention & Early Intervention	HERE Now	Provides school based suicide prevention education and intervention services to middle school, high school, and Transition Age Youth	Reduces suicide ideation, suicides, bullying and the negative impact of suicide in schools. Increases education of community and families.	Middle school, high school, and Transition Age Youth	• Education and outreach • Screening • Crisis response training • Short-term early intervention • Referrals	San Diego Youth Services 3255 Wing St. San Diego, CA 92110 (619) 221-8600	All

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
PEI	VF-01	Veterans & Family Outreach Education	Courage to Call	Provides confidential, peer- staffed outreach, education, referral and support services to the Veteran community & families and its service providers	Increase awareness of the prevalence of mental illness in this community. Reduces mental health risk factors and/or stressors. Improves access to mental health and PEI services, information and support	Veterans, active duty military, Reservists, National Guard, and family members	• Education • Peer counseling • Linkage to mental health services • Mental health information • 7/24/365 Support hotline	Mental Health Systems, Inc. (MHS) 9445 Farnham St., Suite 100 San Diego, CA 92123 (858) 636-3604	All
INN	INN-18	Peripartum Program	Accessible Depression and Anxiety Peripartum Treatment (ADAPT)	Identifies at-risk peripartum women for engagement and provides services for women and spouses	Reduce incidence and impact of postpartum depression	Peripartum women and partners, especially in communities at-risk of trauma	• Outreach and engagement through public health nurses • Interventions to prevent and treat postpartum depression	Vista Hill Foundation 6070 Mission Gorge Road San Diego, CA 92120 (858) 514-5100	All
INN	INN-19	Telemental Health	BH Connect	Outpatient mental health services including crisis intervention, individual and family therapy, individual rehab,case management services utilizing tele-therapy/technolgy platform for children, youth and adults discharging from an emergency psychiatric service setting who are unconnected to a mental health provider.	Prevent re-hospitalization and psychiatric emergency services with follow up mental health services for successful connection to mental health treatment following a psychiatric emergency	Children, Transition Age Youth, Adults/Older Adults who have accessed psychiatric emergency services but are unconnected.	Follow-up mental health treatment and stabilization via tele-therapy including; • individual/family treatment • care coordination • case management • rehabilitative services • outreach and engagement	Vista Hill Foundation 8825 Aero Dr., Suite 315 San Diego, CA 92123 (858)378-2093	All
INN	INN-20	ROAM Mobile Services	Roaming Outpatient Access Mobile Services (ROAM) - Indian Health Council	Mobile clinics provide culturally appropriate mental health services in rural areas	Increase access to and usage of mental health services through deployment of cultural brokers in mobile clinics on tribal lands	Native Americans in rural areas of San Diego County in the North Inland Regions	• Outreach and engagement • Telemedicine • Counseling and clinic services • Telemedicine • Traditional interventions via cultural brokers	Indian Health Council, Inc. 50100 Golsh Road Valley Center, CA 92082 (760) 749-1410	2, 5
INN	INN-20	ROAM Mobile Services	Roaming Outpatient Access Mobile Services (ROAM) - Southern Indian Health Council	Mobile clinics provide culturally appropriate mental health services in rural areas	Increase access to and usage of mental health services through deployment of cultural brokers in mobile clinics on tribal lands	Native Americans in rural areas of San Diego County in the East Regions	• Outreach and engagement • Telemedicine • Counseling and clinic services • Telemedicine • Traditional interventions via cultural brokers	Southern Indian Health Council, Inc. 4058 Willows Rd. Alpine, CA 91901 (619) 445-1188	2
INN	INN-21	ReST Recuperative Housing	Recuperative Services Treatment (ReST)	Provides post-institutionalization recuperative residential services, includes wrap-around services, case management, and permanent housing help	Prevent re-institutionalization and homelessness; encourages successful re-integration following institutionalization	Transition Age Youth	• Wrap-around services • Case management • Voluntary residential services • Employment and permanent housing support	Urban Street Angels, Inc. 3304 Idlewild Way San Diego, CA 92117 (619) 255-1842	All
INN	INN-22	Med Clinics	Center for Child and Youth Psychiatry (CCYP)	Outpatient psychiatric evaluation and medication support services utilizing face-to-face and telepsychiatry/telehealth practices for children and youth with complex psychiatric pharmacological needs.	Promote stabilization by providng psychiotropic medication support to children and youth, who require complex medication management.	Children and youth up to age 21 requiring on-going medicaiton support who have successfully completed a comprehensive mental health treatment with a system of care provider.	• Medication management • Psychiatric consultation • Outreach and engagement • Psycho-educational seminars and groups for families	New Alternatives 8755 Aero Dr., Suite 306 San Diego, CA 92123 858) 634-1100	All
INN	INN-24	Early Psychosis Evaluation and Learning Health Care Network	Early Intervention for Prevention of Psychosis; Kickstart	Provide a collaborative Learning Health Care Network to support quality improvements, consumer engagement and provide use of measurement-based care in early psychosis (EP) programs.	Develop an Early Psychosis LHCN software app to support ongoing collaborative data-driven learning and program development to evaluate the effect of San Diego provider on consumer and program level outcomes.	Individuals served by Pathways Community Services' Kickstart program (contract 552662)	This is a software development contract	University of California, Davis 4701 X St. #1207 Sacramento, CA 95817 (916) 734-3247	All

Component	Work Plan	RER Program Name	Program Name	Program Description	Contact Information	Districts
WET	WET-02	Behavioral Health Training Curriculum (BHTC)	Behavioral Health Training Curriculum	The Behavioral Health Training Curriculum provides training and technical assistance to County and County contracted behavioral health staff on best practices that incorporate principles of trauma informed care, cultural competency, and mental health/substance use co-occurring disorders and primary care/behavioral health integration. Training is provided in all mediums: in-person, eLearning, and webinar.	San Diego State University Research Foundation 5250 Campanile Dr. San Diego CA 92182 (619) 594-1900	All
WET	WET-04	Community Psychiatry Fellowship	The Residency and Internship Program (Community Psychiatry Program)	Programs are for physicians and public mental health nurse practitioners with one program for adult psychiatry residents and fellows and another program for child and adolescent psychiatry residents and fellows and up to seven public mental health nurse practioners who are studying at local universities. Programs foster the development of leaders in Community Psychiatry and provide exposure to the unique challenges and opportunities, and targeted approaches to ethnically and linguistically diverse populations.	Regents of the University of California, UCSD 200 West Arbor Dr. San Diego, CA 92103 (619) 471-9396	All
WET	WET-03	Consumer & Family Academy	Peer Specialist Training	Provide recovery-oriented, peer specialist training to adults 18 years and older to prepare them to work in the County of San Diego's public behavioral health system. Using the training participants' personal recovery experiences as a foundation to prepare participants to work as partners at the practice, program and policy levels. Additional training will be provided to behavioral health providers to facilitate the best use of the unique skills peer specialist staff	Recovery Innovations, International 3838 Camino del Rio North, Ste. #380 San Diego, CA 92108 (858) 274-4650	All
WET	WET-02	Cultural Competency Academy	Cultural Competency Academy	The Cultural Competency Academy (CCA) provides training to BHS and BHS contracted staff with trainings focused on clinical and recovery interventions for multicultural populations. The goal of CCA is to provide awareness, knowledge and skill-based trainings, while ensuring continued focus on being trauma informed from environmental to clinical applications.	San Diego State University Research Foundation 5250 Campanile Dr. San Diego, CA 92182 (619) 594-1900	All
WET	WET-03	Public Mental Health Academy	Public Mental Health Academy - Academic Counselor	Provide an academic counselor to support student success in the community based public mental health certificate program. This certificate program assists individuals in obtaining educational qualifications for current and future behavioral health employment opportunities. The certificate program provides options for individuals to be matriculated into an Associates and/or Bachelor Degree program to assist in the career pathway continuum	San Diego Community College District 3375 Camino Del Rio South San Diego, CA 92108 (619) 388-6555	All

Component	Work Plan	RER Program Name	Program Name	Program Description	Contact Information	Districts
WET	WET-02	Training and Technical Assistance	Training and Technical Assistance	Provide administrative and fiscal training support services to County of San Diego Health and Human Services, Behavioral Health Services (BHS) in the provision of training, conferences and consultants. RTC shall contact trainers/consultants, develop and execute training contracts between RTC and trainers/consultants, coordinate with BHS staff, facilitate payments to trainers/consultants and all approved ancillary training costs.	Regional Training Center 6155 Cornerstone Ct., Suite 130 San Diego, CA 92121 (858) 550-0040	All

APPENDIX D

MHSA JUSTICE INVOLVED PROGRAMS

Population Served	*Program Name and Description*	*FY 2021-22 MHSA Annual Update Plan Funding**	*MHSA Component*
All Ages	The **Psychiatric Emergency Response Team (PERT)** provides mental health consultation, case coordination, linkage to services and limited crisis intervention services for individuals with mental illness who come in contact with law enforcement officers.	$ 9,377,617	CSS
Youth	The **Bridgeways** program is a newly redesigned juvenile justice program that provides comprehensive services to address the behavioral health needs of justice involved youth or youth at risk of justice involvement. The program provides outpatient clinical services, field supportive services, and institutional services with the primary goal of establishing a unified continuum of care that allows for coordination of services within and outside the detention facilities.	$ 560,000	CSS
Youth	The **County of San Diego Juvenile Forensics** team provides mental health and case management services to children and youth in juvenile detention facilities to ensure they are able to successfully reintegrate into the community and to reduce recidivism.	$ 1,100,000	CSS
Youth	**Mobile Adolescent Service Team (MAST)** is an outpatient treatment program that serves children and youth in the community who are involved with the justice system. The program enhancement allows for increased psychiatry coverage.	$ 1,534,058	CSS
Youth	**Outpatient Perinatal Recovery Centers** are adding more mental health clinicians who identify and provide interventions for co-occurring disorders. The women served by this program, who are generally involved in Drug Dependency Court, often come to treatment with their young children, who also receive supportive mental health services through a mental health clinician that works with the caregiver and child.	$ 1,235,401	CSS
Youth	**Juvenile Court Clinic** provides assessment, medication management services and case management for juveniles involved in the Court system.	$ 847,000	CSS
Transitional Age Youth	The **Full Service Partnership (FSP) Assertive Community Treatment (ACT) program for Transition Age Youth (TAY)** provides services to TAY who are homeless, may have been referred by jail services, are experiencing serious mental illness (SMI), and who may also have a co-occurring substance use disorder.	$ 5,250,116	CSS
Adults	The **Faith Based Wellness and Mental Health Inreach Ministry** program focuses on adults diagnosed with SMI while in jail and also engages individuals with schizophrenia or bipolar disorders to provide spiritual support, wellness education for physical and mental health, and linkages to community- based resources for reintegration into the community.	$ 949,690	CSS
Adults	The **Justice Integrated Full Service Partnership (FSP) Assertive Community Treatment (ACT)** program provides services to homeless adults with a SMI who may also have a co-occurring substance use disorder. Clients served are system involved and have received mental health services while in detention. An array of housing options is provided to enrolled clients. Includes new program rows added to Center Star.	$ 6,420,167	CSS
Adults	The **Full Service Partnership (FSP) Assertive Community Treatment (ACT) for Persons with High Service Usage and Persons on Probation** program provides multidisciplinary, wraparound treatment and rehabilitation services, along with housing.	$ 3,055,060	CSS
Adults	The **Collaborative Behavioral Health Court and Assertive Community Treatment** program focuses on adults in the Central Region who are referred by the Court for services as an alternative to custody.	$ 1,876,000	CSS
Adults	The **Public Defender Discharge and Short Term Case Management Service** adds two licensed mental health clinicians to provide discharge planning, care coordination, referral and linkage to services, and short term case management for persons with SMI who have been referred by the Court for services.	$ 240,000	CSS
Adults	**Justice System Discharge Planning**, or Project Enable, provides in-reach services to assist with discharge planning and short- term transition services for clients who are in jail and identified to have SMI, to assist in connecting clients with community-based treatment once released**.**	$ 925,000	CSS
Adults	**Probation Officers for BH Court and FSPs** are dedicated to specific Assertive Community Treatment teams to provide support and case management of individuals with SMI who are on probation.	$ 585,000	CSS
Adults	The **Behavior Health Assessor** is a program within the Lemon Grove Family Resource Center that provides screening, assessment and linkage for mental health and/or drug and alcohol issues for offenders prior to and/or following release to determine need and level of care.	$ 250,000	CSS
Adults	The **BH Assessor** is a program for Courts in South and Central Regions the provides screening, assessment and linkage for mental health and/or drug and alcohol issues for offenders prior to and/or following release to determine need and level of care.	$ 435,000	CSS
Adults	The **Veterans & Family Outreach Education** program, or Courage to Call, is a veteran peer-to-peer support program staffed by veteran peers. The program provides countywide outreach and education to address the mental health conditions that impact veterans, active duty military, reservists, National Guard, and their families (VMRGF), and provides training to service providers of the VMRGF community. This program includes navigator assistance in Veterans' Court for those involved with the justice system.	$ 1,280,000	PEI
Grand Total		**$ 35,920,109**	

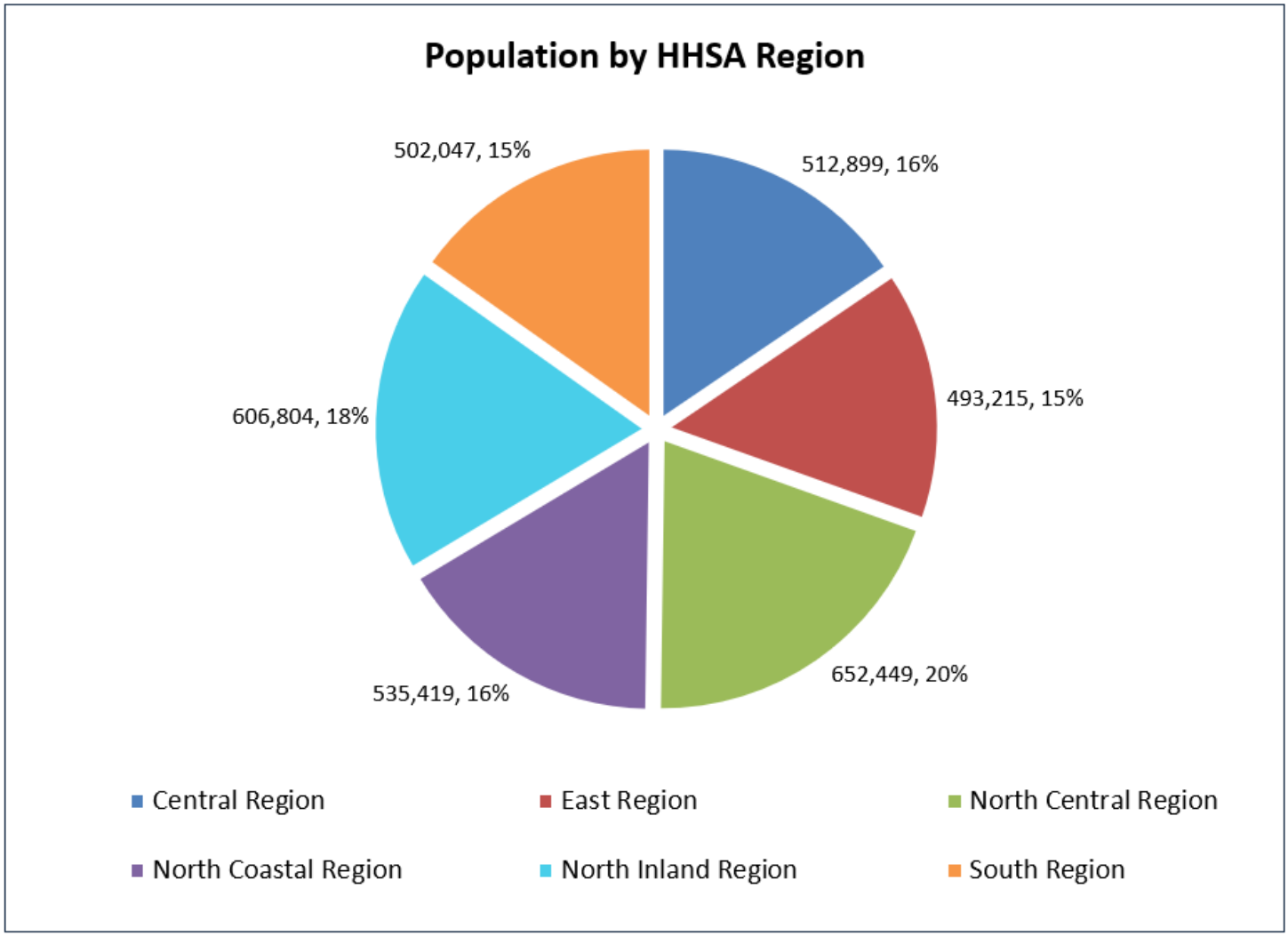
*Represents total BHS funding allocated to the program, including MHSA, Medi-Cal and Realignment. It does not include funding from other departments (if applicable). Programs may also serve non-justice system involved clients. Programs for the general population that also serve justice system involved clients are not included in these totals.

APPENDIX E

COUNTY OF SAN DIEGO DEMOGRAPHICS

POPULATION

HHSA Region	Population	%
Central Region	512,899	16%
East Region	493,215	15%
North Central Region	652,449	20%
North Coastal Region	535,419	16%
North Inland Region	606,804	18%
South Region	502,047	15%
San Diego County	**3,302,833**	**100.0%**



Source: U.S. Census Bureau; 2014-2018 American Community Survey 5-Year Estimates.

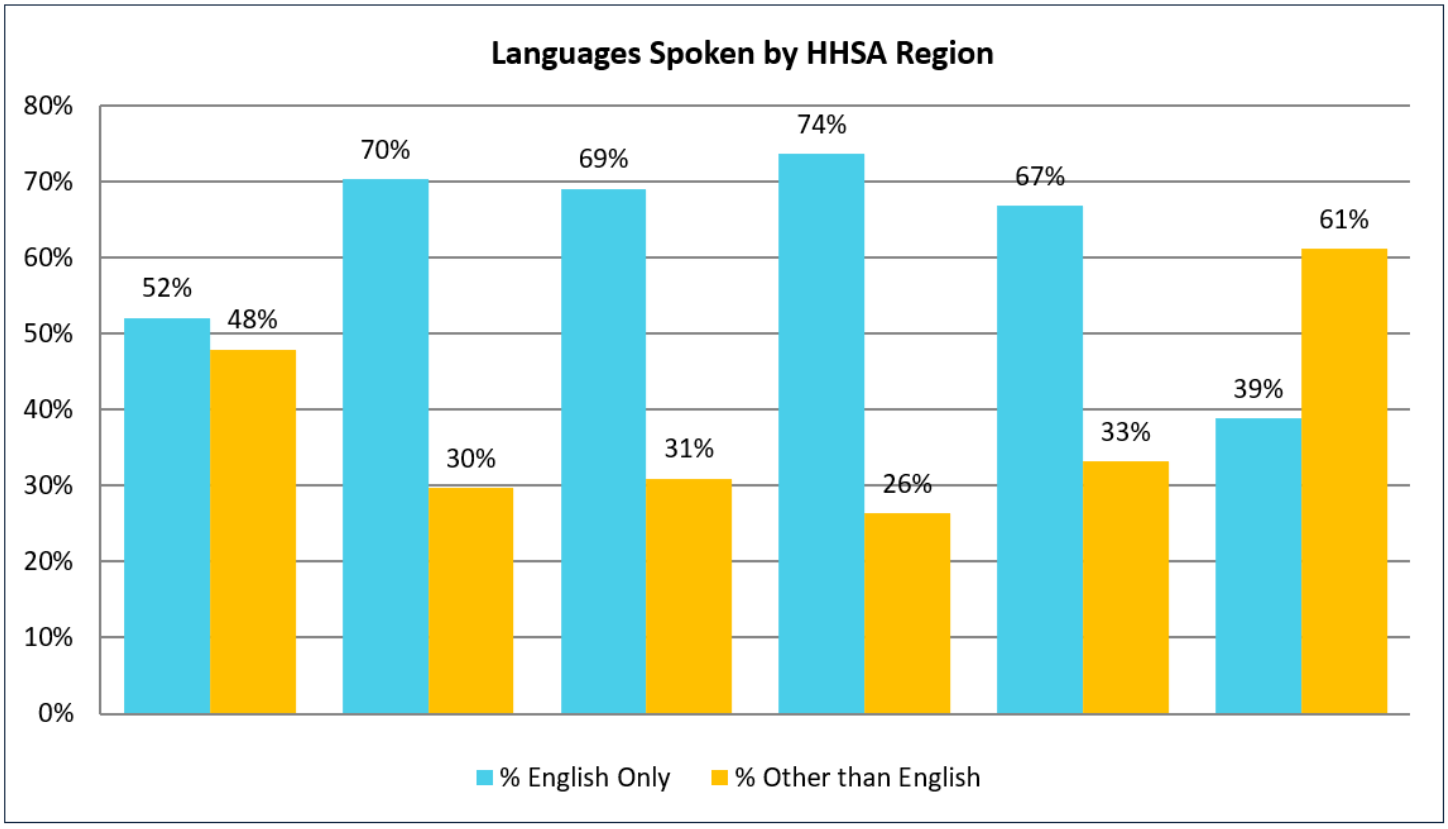
RACE/ETHNICITY

HHSA Region	*White*	*Black or African American Alone*	*American Indian and Alaska Native Alone*	*Asian Alone*	*Native Hawaiian and Other Pacific Islander Alone*	*Some Other Race Alone*	*Two or More Races*	*Hispanic or Latino*
Central Region	154,089	57,884	1,109	64,516	2,086	758	14,432	218,025
East Region	280,683	27,647	2,675	22,941	2,477	762	19,638	136,392
North Central Region	367,104	22,016	1,789	124,858	2,291	1,908	27,202	105,281
North Coastal Region	311,506	16,322	1,719	31,821	1,816	999	15,633	155,603
North Inland Region	308,128	11,495	4,195	72,187	1,721	1,081	21,364	186,633
South Region	93,870	20,172	795	66,013	2,420	858	12,928	304,991
San Diego County	**1,515,380**	**155,536**	**12,282**	**382,336**	**12,811**	**6,366**	**111,197**	**1,106,925**

Source: U.S. Census Bureau; 2014-2018 American Community Survey 5-Year Estimates.

LANGUAGE SPOKEN (5 YEARS OLD AND GREATER)

HHSA Region	*Total Population 5 Years Old and Greater*	*English Only (5 Years Old and Greater)*	*% English Only*	*Language Other than English (5 Years Old and Greater)*	*% Other than English*
Central Region	481,484	250,783	52%	230,701	48%
East Region	459,952	323,449	70%	136,503	30%
North Central Region	614,202	424,184	69%	190,018	31%
North Coastal Region	500,501	368,512	74%	131,989	26%
North Inland Region	565,321	377,672	67%	187,649	33%
South Region	469,404	182,365	39%	287,039	61%
San Diego County	**3,090,864**	**1,926,965**		**1,163,899**	

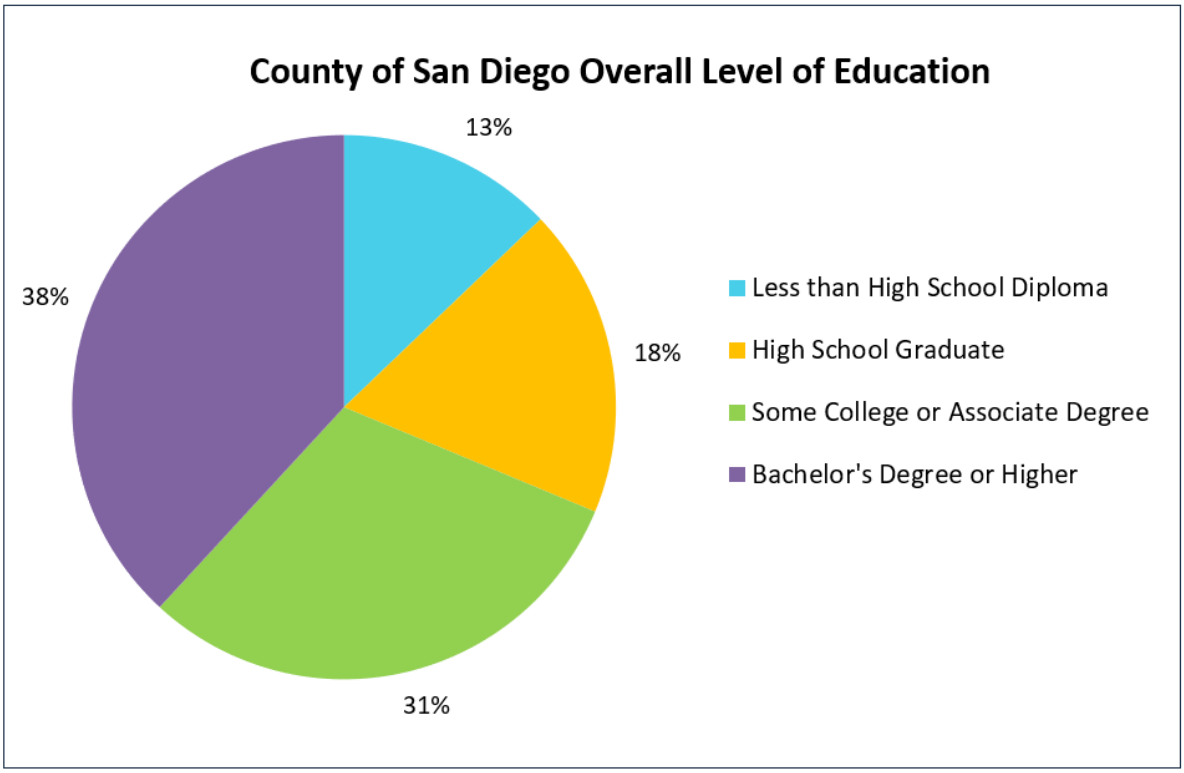


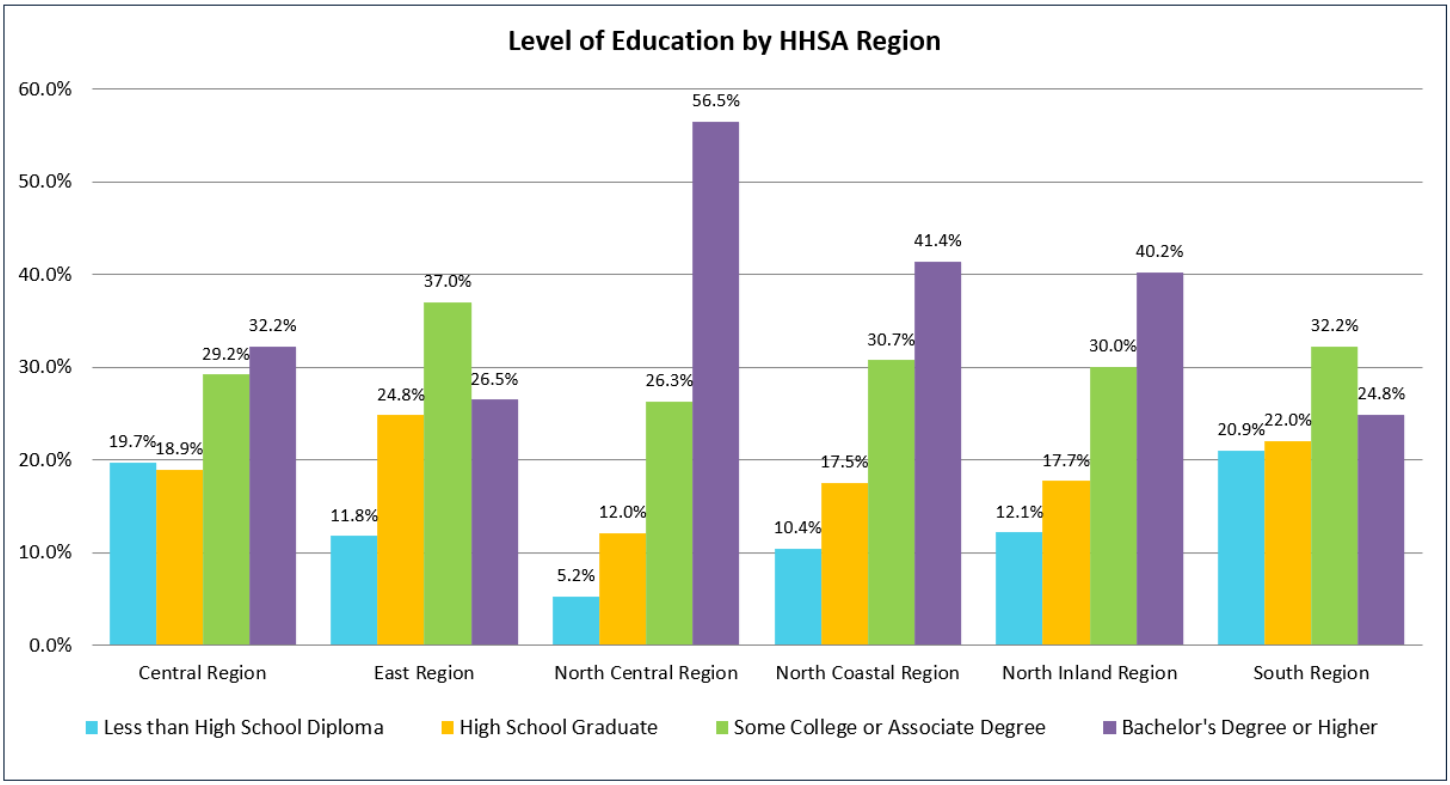
Source: U.S. Census Bureau; 2014-2018 American Community Survey 5-Year Estimates.

LEVEL OF EDUCATION

HHSA Region	Population 25 and Older	Less than High School Diploma	High School Graduate	Some College or Associate Degree	Bachelor's Degree or Higher
Central Region	347,349	68,473	65,610	101,338	111,928
East Region	335,268	39,410	83,123	124,013	88,722
North Central Region	454,549	23,833	54,771	119,349	256,596
North Coastal Region	353,463	36,718	61,984	108,589	146,172
North Inland Region	407,615	49,481	72,135	122,130	163,869
South Region	325,132	68,093	71,649	104,655	80,735
San Diego County	**2,223,376**	**286,008**	**409,272**	**680,074**	**848,022**
% of Total	**100%**	**13%**	**18%**	**31%**	**38%**

HHSA Region	Population 25 and Older	Less than High School Diploma	High School Graduate	Some College or Associate Degree	Bachelor's Degree or Higher
Central Region	100%	19.7%	18.9%	29.2%	32.2%
East Region	100%	11.8%	24.8%	37.0%	26.5%
North Central Region	100%	5.2%	12.0%	26.3%	56.5%
North Coastal Region	100%	10.4%	17.5%	30.7%	41.4%
North Inland Region	100%	12.1%	17.7%	30.0%	40.2%
South Region	100%	20.9%	22.0%	32.2%	24.8%

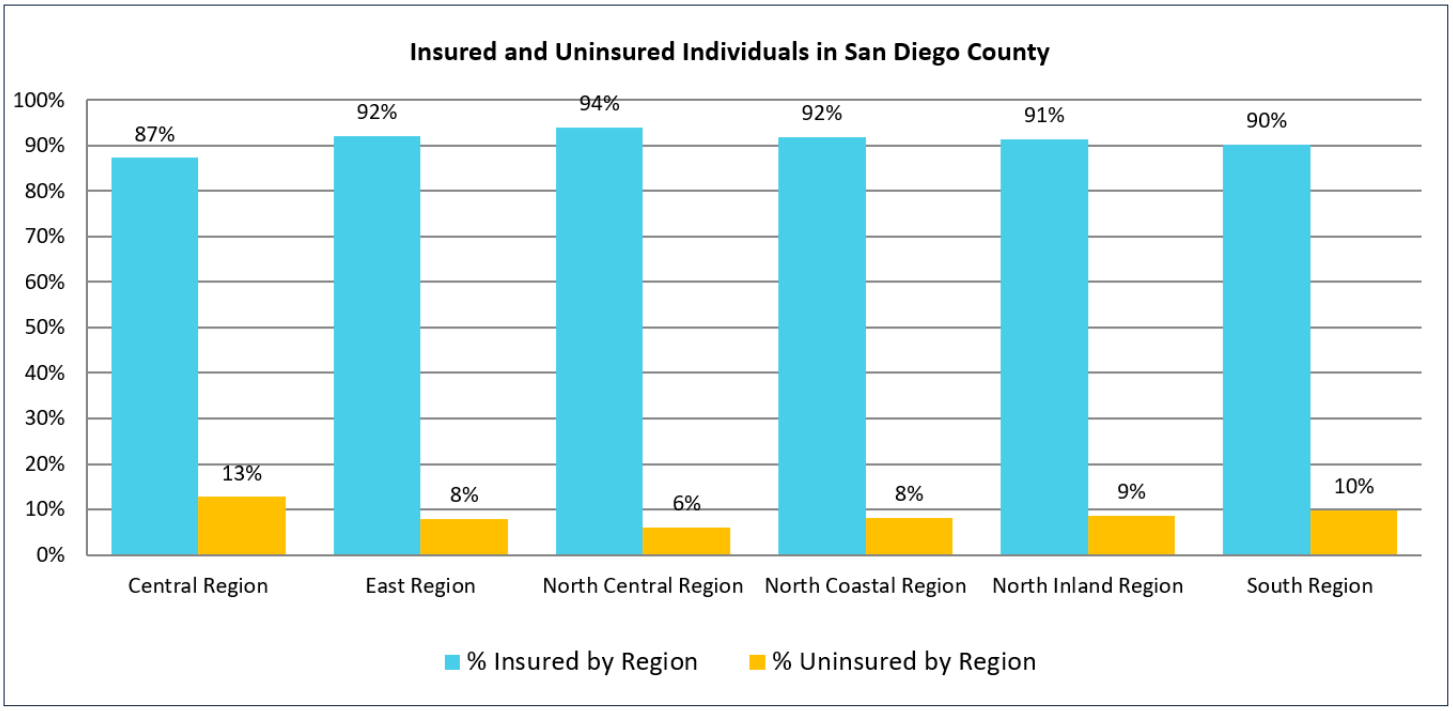




Source: U.S. Census Bureau; 2014-2018 American Community Survey 5-Year Estimates.

INSURED AND UNINSURED

HHSA Region	Health Insurance Population	Insured Individuals	% Insured by Region	Uninsured Individuals	% Uninsured by Region
Central Region	497,680	434,340	87%	63,340	13%
East Region	481,142	443,076	92%	38,066	8%
North Central Region	634,286	596,206	94%	38,080	6%
North Coastal Region	507,919	466,592	92%	41,327	8%
North Inland Region	601,274	549,703	91%	51,571	9%
South Region	482,169	434,951	90%	47,218	10%
Total San Diego County	**3,204,470**	**2,924,868**		**279,602**	



Source: U.S. Census Bureau; 2014-2018 American Community Survey 5-Year Estimates.

APPENDIX F

COMMUNITY ENGAGEMENT REPORT 2021

County of San Diego Health and Human Services Agency Behavioral Health Services Community Engagement Report Fiscal Year 2020-21

Reported by

The Institute for Public Health
School of Public Health
San Diego State University

March 2021



SAN DIEGO STATE UNIVERSITY

Institute for Public Health

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EXECUTIVE SUMMARY

The County of San Diego Health and Human Services Agency, Behavioral Health Services (BHS) provides mental health and substance use disorder prevention and direct services for adults, children, and youth within the San Diego county region. Through programs offered by the County, contractors, and individual fee-for-service providers, BHS serves more than 111,000 people annually. BHS actively partners with law enforcement and justice organizations, community health centers, hospitals, and other community-based organizations to provide care that meets individual's immediate needs and helps support long-term recovery. BHS's work aligns with County's *Live Well San Diego* vision to ensure that the residents of San Diego are healthy, safe, and thriving.

Each year BHS solicits feedback from the community about behavioral health needs to gather input about how to better serve San Diego residents and meet the requirements of the Mental Health Services Act. Community members are asked to discuss pressing behavioral health issues and ways to better engage and serve the community; they also brainstorm ideas about new programs and services. Community input is used to inform the development of new programs and/or the expansion or modification of existing programs. The community engagement process is designed to identify and gather information regarding the needs of regional unserved and underserved populations.

For the Fiscal Year 2020-21 community engagement process, the Institute for Public Health (IPH) at San Diego State University (SDSU) worked with BHS to schedule and facilitate community engagement events. This year, the events were conducted virtually in compliance with local COVID-19 stay at home orders and gathering guidance.

Two virtual community listening sessions – one designed for behavioral health care providers and the other for youth and families – were held. In addition, 11 focus groups were hosted that prioritized communities of identity and/or geography. Finally, 10 one-on-one phone interviews were conducted.

Participants in this year's engagement process were asked to describe what behavioral health problems they were observing in the community, with a specific focus on how the recent pandemic and other factors have impacted behavioral health. They also shared their ideas about what topics BHS should address moving forward and what could be done to ensure the strength and resiliency of the community. Participants completed an online survey after each event to evaluate the efficacy of the engagement activity. Results showed that, overall, participants were very satisfied with the process.

Recruitment efforts for the engagement were expanded from previous years. This was necessary due to identified challenges of potential participants due to concurrent pandemic. It was noted that participants might be facing barriers to participation due to distancing

guidelines. Community engagement events were held during the surge in COVID-19 infection rates that occurred November 2020 through January 2021. Nevertheless, event attendance totaled 201, close to the number of attendees at last year's engagement. This included 158 participants in the community listening sessions, 33 participants in the focus groups, and interviews with 10 people.

The primary finding of this year's engagement, owing to the circumstance of the pandemic, reflected the public's recognition of an ongoing and potentially worsening behavioral health crisis. Underlying this crisis was a slow transition to a telehealth mode, assurance that all individuals had access to and were comfortable with virtual services, assessment of people who were isolated at home, and meeting the basic survival needs of community members. The utilization of behavioral health services has decreased, which may fuel the crisis. In addition, the community identified growing, overt racism as contributing to the crisis. Community members identified higher levels of anxiety and depression, growing substance use issues, and disproportionate behavioral health impacts.

Ten actions were suggested to address the behavioral health crisis, including:

1. Increase the use of peer mentors.
2. Develop culturally, linguistically, and developmentally appropriate outreach and engagement efforts and deliver public health messaging through multiple methods.
3. Develop community-based, community-designed, and community-staffed behavioral health services.
4. Recognize that basic needs and behavioral health needs are connected and integrate services to meet those needs.
5. Address racism.
6. Create specific school-based care and services for youth.
7. Provide professional development and offer more support to behavioral health service providers.
8. Implement non-traditional approaches to behavioral health support.
9. Re-evaluate the substance use disorder continuum of care.
10. Create a comprehensive plan to address short and long-term behavioral health impacts from the current crises and to prepare for future crises.

Four overarching themes emerged from the events: prepare, integrate and coordinate, build trust, and combat stigma and shame. Preparedness must be prioritized both to meet the "tsunami of need" that is emerging and plan for future crises, according to attendees. Preparation should take place at the state and local levels and include policy changes, support for behavioral health service providers, systems of needs assessment for vulnerable populations, and the creation and retention of a diverse behavioral health service workforce.

Next, care for behavioral health needs must include meeting basic needs for employment, shelter, food, and others to be effective – integrating and coordinating care for these needs and taking a more holistic approach is more effective. Third, trust between communities and governmental organizations must be re-established. Efforts to build trust must include a direct acknowledgement of historic and current racism and the incorporation of anti-racist practices. Finally, the community emphasized that, for many people, admitting to and seeking help for behavioral health problems is deeply shameful. Coordinating care, building trust, having a representative workforce, allowing for non-traditional approaches, and ensuring that behavioral health messaging and services are created and delivered by people within communities, along with a comprehensive behavioral health education program in schools will help combat the stigma associated with behavioral health issues.

The IPH staff are grateful for the community's willingness to attend events and share their ideas. The feedback was rich and honest and will provide invaluable direction to BHS for prioritizing, expanding, and updating its programs and services.

INTRODUCTION

The County of San Diego Health and Human Services Behavioral Health Services department (BHS) strives to improve the well-being of San Diego's 3.3 million residents through serving as a health plan, provider, and contractor to provide preventive and treatment services for mental health and substance use issues. Programs and services are provided both by the County and in partnership with contracted providers and individual fee-for-service providers, who, together, serve nearly 111,000 people each year. Funding is provided, in part, by the Mental Health Services Act (MHSA). The goal of MHSA is to increase access to behavioral health services and reduce disparities in the delivery of services for unserved and underserved Californians.

One requirement of MHSA funding for all California counties is to carry out a Community Program Planning process that engages the community in directing priorities for MHSA funding. BHS meets this requirement by hosting annual community engagement events, such as listening sessions, focus groups, and interviews, to which the public are invited. These events allow community members an opportunity to discuss significant behavioral health concerns in San Diego and to come together to find ways to address them. In addition to meeting MHSA requirements, this process also supports San Diego County's *Live Well San Diego* vision of "building better health, living safely, and thriving." Feedback collected informs the development of new programs and services as well as the expansion and modification of existing programs and services.

The Fiscal Year 2020-21 community engagement process was co-hosted by BHS and San Diego State University's Institute for Public Health (IPH). The IPH was responsible for recruitment, logistical arrangements, facilitation, data collection, data analysis, and the production of this report. BHS provided leadership, designation of audiences to engage, connections to community leaders and organizations, and guidance about the structure and focus of the events.

Community engagement for the Fiscal Year 2020-21 differed significantly from previous years due to the COVID-19 pandemic. All events were held virtually, and recruitment efforts were amplified as community members reported being too overwhelmed to participate. Engagement events occurred during the most significant surge of COVID-19 cases in San Diego County.

The Fiscal Year 2020-21 engagement process included two large listening sessions, hosted on the Zoom virtual meeting platform. One was for providers of behavioral health services. The other was for families and youth. Youth who participated were offered community service hours for attendance. In addition, 11 virtual focus groups were arranged for specific communities of identity and/or geography. Two virtual focus groups had no attendees, so data were collected from nine of these smaller sessions. Finally, ten interviews were performed.

The methods used by the IPH and the findings of the engagements are presented in the first and second sections of this report. Overarching themes that emerged from the findings are discussed in the third section of the report. A comparison of this year's results with previous years' results is presented in section four. The results of the satisfactions surveys, along with the IPH's recommendations for future engagement efforts are included in the final section.

PROCESS AND METHODOLOGY

BHS and the IPH began planning for the community engagement process in August 2020. The first focus group was held on November 12, 2020, and the first community listening session was held on December 1, 2020. One-on-one interviews were conducted throughout December 2020 and into February 2021. The engagement process officially concluded in February 2021. Details about the planning process, the facilitation of events, recruitment efforts, and the methods of data analysis are provided below.

Collaborative Planning

The IPH worked in collaboration with BHS to select dates and to determine best approaches for the promotion of the community engagement, recruitment of community members, facilitation of community listening sessions and focus groups, and data collection and analysis.

Initial weekly meetings with BHS focused on finalizing topics and priority populations and ensuring that events were scheduled across a variety of days and times that would be amenable to high rates of community participation. Subsequent meetings focused on details of the process including recruitment, promotion, data collection, logistics, and facilitation. Ad hoc phone and in-person meetings were also held, as necessary.

BHS and IPH staff attended multiple meetings of the Cultural Competency Resource Team (CCRT) and the Behavioral Health Advisory Board (BHAB) to consult with their members about outreach efforts, topics, and approaches to facilitation. Their input was invaluable in ensuring that events were as culturally competent as possible and relevant to community members.

Engagement Approach

Due to social distancing protocols of the COVID-19 pandemic, the IPH employed a virtual meeting approach to collecting feedback. Multiple online platforms were explored for hosting. Zoom was selected as the online platform because the IPH has access to the SDSU professional Zoom platform with strong security features, and because of public familiarity of Zoom. At a minimum, a person only need access to a phone to participate. This platform allowed for up to 300 people to participate in any given meeting.

The team's goal was to maximize participation while minimizing the burden on behavioral health service providers and community members. It was decided, therefore, that two primary large-group events would be held: one specifically for behavioral health service providers and one for community members with a special focus on families and youth. This decision was made, in part, based on feedback from previous years' events that it was important to have separate discussions for providers and community members. Providers wanted the opportunity to speak with each other and address professional concerns, and community members wanted an opportunity to speak about their concerns without worrying about privacy or about offending service providers. In addition, youth who attended last year's forums expressed an interest in continuing to participate, so it was important to offer them this opportunity. Youth were offered separate break out rooms in the second listening session so that they could speak freely. They were also able to receive community service credit for attending the listening session.

The team also felt that it was important to hear from communities of identity and geography who have been disproportionately impacted by the recent crises. After examining data showing disproportionate the impacts of COVID-19 on certain populations in San Diego, and in consultation with stakeholders and BHS leadership, the following groups were identified for focus group participation: LatinX, Asian/Pacific Islander, and Black individuals, behavioral health care providers who are essential workers, people receiving services for serious mental illness or for substance use disorders, the loved ones of people with serious mental illness or substance use disorders, and people living in rural areas. In addition, because of their special expertise in working with traumatized populations, a focus group was held with the San Diego Trauma-Informed Guide Team, which is made up of providers with expertise in trauma-informed approaches to behavioral health care.

In addition, it was decided that everyone participating in these groups would be offered an opportunity for a one-on-one interview and/or to submit written feedback via email or an online form. The online feedback form, along with an interview request form, was also posted on the listentosandieo.org website. Paper copies of these forms were provided to the CCRT and the BHAB for distribution to stakeholders who might not have access to the internet. The team also specifically solicited interviews, among the African American and Asian/Pacific Islander community, for example, when more participation was needed from a particular perspective and/or community.

The use of multiple approaches to engagement, ensured that every member of the community had an opportunity to provide feedback in whatever way was meaningful and accessible to them: larger listening sessions, smaller, targeted focus groups, one-on-one interviews, or in writing.

Special Considerations

Transitioning the community engagement process to a virtual effort created unique challenges that required special considerations. The IPH reviewed and investigated privacy and security measures necessary to ensure the confidentiality of participants, processes for ensuring participating minors had parental consent, and how to navigate the lack of access to technology for the target populations. The engagement team came up with the following plan to meet these challenges while remaining responsive to community needs:

- Concerns around unregistered participants (or "Zoom Bombers") accessing the engagement sessions were allayed by the development of waiting room protocols, allowing for only registered participants to be admitted into the event.
- Zoom session links were not sent out until 2-3 days prior to the sessions to reduce the likelihood of the link being shared publicly. They were sent again either the day before or the morning of the event.
- Participating minors were required to provide a parent or guardian email address at the time of registration so that email notifications could be sent to the parent to ensure knowledge of their child's participation in the engagement process.
- A phone number and email address were published on fliers and in emails so that those who could not access virtual environments could request a one-on-one interview. Additionally, because each engagement session allowed for call/dial-in participation via a cell phone or landline, a computer or internet connection was not required to participate.
- Participants interested in the engagement process but concerned about anonymity and confidentiality were offered: (1) a phone number and email address to contact to request a one-on-one interview; (2) a fillable online engagement form available on the ListentoSanDiego.org website; and (3) were not required to use video to participate in the Zoom engagement sessions.
- The chat function within each Zoom session and each breakout-room was configured to allow for communication only to and from the hosts so that participants had a way to communicate confidentially with facilitators. This also prohibited participant to participant heckling and/or negative feedback.

Topics

This year's community engagement focused on the behavioral health impacts of the COVID-19 pandemic and overt incidents of social injustice while at the same time allowing for discussion of concerns unrelated to these circumstances. As such, the primary questions presented at the groups this year related to identifying critical behavioral health concerns in the community with specific probes about the impacts of the pandemic and episodes of social and racial injustice.

The community was also asked to discuss the ways in which they would like BHS to address those concerns. Several prompts were employed as needed to elicit conversation. The questions utilized at community listening sessions are presented below in Figure 1. These questions were also used for interviews. The questions used for focus groups were similar. For details about focus group questions and discussion prompts, please see Appendix 1.

Figure 1. Questions and Prompts Utilized During Community Listening Sessions

Question 1: What are the most serious mental health concerns in your community right now?
Discussion Prompts:

- Have these changed in recent months?
- Has the pandemic affected the mental health of people in your community? If so, has your ability to get care for yourself or loved ones been impacted?
- Have the recent incidents of social injustice affected the mental health of people in your community? If so, how?
- What would help minimize these impacts?
- What would help people restore hope?

Question 2: What are the most serious substance use issues in your community right now?
Discussion Prompts:

- Have these changed in recent months?
- Has the pandemic affected substance use issues for people in your community? If so, how, and has your ability to get substance use treatment for yourself or loved ones been impacted?
- How have the recent incidents social injustice affected substance use issues for people in your community? If so, how?
- What would help minimize these impacts?

Question 3 (Family and Youth Listening Session Only): What do you need to make sure {you} (for teens/ {your family}) (for adults) come out of the recent crises stronger than ever?
Discussion Prompts:

- What types of programs and services have been helpful to you during this time?
- How can BHS support you/your families?
- What services and programs are needed moving forward?
- What types of treatment services are needed?
- What types of preventive services are needed?
- What kind of public messaging is needed?

Question 3 (BHS Provider Listening Session Only): What do the people you serve need from San Diego County BHS to address these issues?

Discussion Prompts:

- What services and programs have been helpful over the past several months for the people you provide services for?
- How, as providers of behavioral health services, have you been impacted by COVID-19 and other issues facing our communities?
- What should BHS be thinking about moving forward?
- What types of treatment services are needed?
- What types of preventive services are needed?
- What kind of public messaging is needed?

Scheduling

Once topic selection and questions were finalized, the IPH worked to schedule dates and times for the community listening sessions and focus groups. The sessions were planned at varying times of the day and different days of the week to accommodate different schedules of community members.

Table 1. Community Engagement Schedule

Event	Date
Interviews	December 2020 thru February 2021
Trauma Informed Guide Team Focus Group	November 12, 2020
LatinX Individuals Focus Group 1	November 18, 2020
API Individuals Focus Group	November 21, 2020
MH and SUD Service Provider Listening Session	December 1, 2020
LatinX Individuals Focus Group 2	December 2, 2020
Essential Workers Focus Group	December 3, 2020
Loved Ones of Those with SMI Focus Group	December 5, 2020
African American Individuals Focus Group	December 8, 2020
Individuals with SMI Focus Group	December 8, 2020
Family and Youth Listening Session	December 12, 2020
Loved Ones of Those with SUD Focus Group	December 15, 2020
Individuals with SUD Focus Group	December 17, 2020
Rural San Diego/Mtn Empire Focus Group	December 29, 2020

Staffing

The IPH recruited, hired, and trained 16 master's and doctoral level students in the fields of public health, psychology, and social work to help facilitate the engagement events. Two-thirds of the student facilitators were bilingual, speaking Spanish, Japanese, Arabic, Vietnamese, Bengali, Mandarin, and Persian (Farsi and Dari). After undergoing screening and hiring, the students received extensive training about conducting community-based qualitative research and best practices for virtual facilitation. This included training on data collection methods, effective listening session, focus group, and interview facilitation, best practices for facilitating groups in an online environment, and how to handle difficult situations. The students then practiced what they learned in a mock Zoom event before the engagement process began.

Facilitators served as leaders and notetakers for the discussions at listening sessions, focus groups, and interviews. They asked questions and prompts, took notes on the feedback, documented any questions or concerns, and ensured community members felt welcomed, appreciated, and heard. After each event, facilitators wrote up their notes, identified common themes, and submitted these notes to the IPH administrative team for analysis.

Participant Recruitment

To encourage equitable access and participation in the virtual engagement process during a time of great community stress, an expanded and focused recruitment effort was implemented. Student facilitators assisted the IPH staff team with the increased recruitment efforts, which effectively and significantly increased the IPH capacity for event promotion and recruitment.

The sessions were promoted through a variety of communication and media channels including the IPH-developed website, email flyer distribution, cold-call canvassing, digital and print media buys, social media, online public calendars, personal outreach, and other email marketing.

Website

The IPH revised and updated the www.ListentoSanDiego.com ADA compliant website, initially deployed for the 2018 BHS Community Engagement process. The website allowed for online registration and gave detailed information about the community engagement process. The website was available in the County's five designated threshold languages: Spanish, Arabic, Tagalog, Vietnamese, and Farsi (screenshots can be viewed in Appendix 2).

Promotional Flyers

The IPH created one promotional flyer for the large public Family and Youth Community Listening Session and one for the Provider Community Listening Session. The County of San Diego Live Well Marketing guidelines were followed and IPH was provided design direction, edits, and feedback prior to production (see Appendix 3). The flyer included date, time, and a

virtual format notification as well as the topic that would be discussed. Registration instructions, including the website address and registration email, were provided.

The flyer was distributed widely via more than 31,200 individual emails. The IPH sent 10,205 emails promoting all opportunities to participate in this year's community engagement process and sent 21,000 emails to the San Diego Reader subscriber list.

One-on-One Personal Recruitment

The IPH compiled a master list of marketing targets including the names of community leaders provided by BHS, organizations that provide prevention or treatment services for individuals with behavioral health issues or support services for their loved ones, religious organizations including churches, synagogues, and mosques, large employers, libraries, YMCAs, community and recreation centers, senior living and retirement communities, and service organizations such as Rotary, Lyons, Shriners, and Soroptimist and Optimist Clubs. These individuals, organizations, and businesses were then contacted through cold-calling, and/or through email. The engagement process was discussed with the person contacted, and a flyer and weblinks were provided. The contacts were asked to distribute the information to their constituents, members, clients and/or employees.

Media Buys

The Family and Youth Community Listening Session was promoted through print and digital media buys. Advertising space was purchased in the San Diego Reader, Star News, East County Californian, Coast News and Coast News Inland, and a Spanish version of the advertisement was placed in the El Latino newspaper. The number of impressions of these ads totaled 337,500. Images of all advertisements can be found in Appendix 4.

Table 2. Newspaper and Online Media Buys

Newspaper	# of Ads	Area of County	Impressions per Ad	Ad Date
San Diego Reader (Print)	1	Countywide	70,000	12/3/2020
San Diego Reader (Online)	1	Countywide	25,000	11/28/2020 thru 12/11/2020
Star News	2	South Bay	67,000	11/27/2020 and 12/4/2020
East County Californian	1	East County	15,500	12/4/2020
Coast News Inland	1	North Coastal Inland	20,000	11/27/2020
The Coast News	1	North Coastal	20,000	12/4/2020
El Latino	2	Countywide	120,000	11/27/2020 and 12/4/2020
Totals	**7**		**337,500**	

Social Media

Numerous posts were made on both the County and IPH social media and networking sites including Facebook, LinkedIn, Instagram, Twitter, and the Nextdoor App with a reach of more than 37,600 people. Social media posts were created and shared by the BHS and IPH teams, San Diego County Live Well and Health and Human Services Agency departments, San Marcos Community News, Olympian High School, and Jewish Family Services. A sampling of screenshots of posts can be found in Appendix 5.

Public Calendars

Online public calendars were utilized as a community wide advertising method to promote the Family and Youth Community Listening Session. Twenty-two calendars were solicited to post the event with six following through. Whenever possible, the digital version of the flyer was attached to the calendar listing. The community listening session was posted to the following online calendars:

- Fox 5 Community Calendar
- KPBS Community Calendar
- PATCH
- 211 Community Calendar
- Eventbrite
- City of Chula Vista Community Calendar

Images of each community calendar posting can be found in Appendix 5.

Email Blasts

Email blasts were conducted by BHS and the IPH, with all BHS staff encouraged to disseminate the promotional flyers, and San Diego County BHS contract providers were invited to attend the BHS Provider Community Listening Session. Additionally, two email blasts were sent out by the IPH to the list of previous participants and registrants from the past two years with topic and event details (see Appendix 6).

Event Processes

Registration

To track the number of participants attending each event and to gather demographic information, participants were asked to register online at ListenToSanDiego.org. The participant data received through were stored in a registration form on Qualtrics, an online survey software. Registration was available and equally accessible in English, Spanish, Arabic, Farsi, Vietnamese, and Tagalog. Upon registration, participants were asked to identify any

special assistance or translation services they needed during the event. A screenshot of the online registration form can be found in Appendix 7.

Registrants were asked to provide basic information, including ZIP code, and identification with listed community groups and special populations. The data recorded through registration are summarized in the Results section.

Because each event was conducted through Zoom, communication with registrants was prioritized. After registering to attend an event, an email was sent to the registrant thanking them for their interest, letting them know that the Zoom meeting link would be sent to them within two days of the event, and advising on how to ensure their technology (Zoom App updates, and camera and microphone configuration) was ready for the meeting. If a registrant requested translation services, an email was sent to them letting them know how to access the specific Zoom audio channel provided to them in their language preference. Additional emails were sent two days prior to the event and either the night before or the morning of the event, both of which included the Zoom meeting link and phone number to connect to the session.

Agendas and Facilitation

Community Listening Sessions

Based on extensive experience conducting community engagement events and on research about best practices for virtual facilitation, the IPH identified several methods necessary to optimize community engagement in a virtual setting. First, the large group must be broken into smaller groups – no larger than 15 – to allow for meaningful discussion; these groups need to be facilitated by staff trained in best practices for qualitative research. Second, these small groups need to be given time to "report out" to the larger group and to hear the results of the other small group discussions to create an open, transparent, and collaborative environment. Finally, the events must be highly structured while allowing for flexibility for unforeseen events.

Utilizing these best practices, the community listening sessions occurred as follows. Sessions were scheduled for an hour and a half block of time. IPH staff launched each Zoom session 20 minutes prior to the start time to accommodate early arrivals, managed the waiting room function, and prepared breakout room assignments for the Listening Sessions.

The first ten minutes of each session was devoted to confirming registration, allowing entrance into the session, and welcoming participants. After the registration process was complete, BHS Director Luke Bergmann, PhD, welcomed participants to the session and emphasized the importance of community feedback. Following Dr. Bergmann's message, the event moderator thanked all attendees for their participation and informed them about the purpose and structure of the session, as well as the topics that would be discussed. The moderator assured participants that their feedback, regardless of the modality in which they provided it, would be incorporated into a comprehensive report for BHS. The moderator also offered assurance that

their feedback would remain anonymous, and that they were not required to remain for the entire duration of the event or answer any questions, should they feel uncomfortable doing so. Finally, the event moderator explained the format and process of the event to the group and the expected timeline. After this introduction, the participants were placed into their assigned breakout rooms and greeted by the room's trained staff facilitators.

The breakout room process was as follows:

Facilitators used approximately 10 minutes for each of the three questions asking their group to identify concerns and thoughts about mental health and substance use and what solutions and services they considered necessary to support their resiliency. If needed, the facilitator followed scripted prompts to elicit further discussions. As the group shared their perspectives and experiences, the facilitators took notes and monitored the chat for comments and feedback from the participants. The facilitator then asked the group to identify the key discussion points of their group for sharing with the larger group. The spokesperson chosen for the group at the beginning of the session was confirmed, and the group returned to the main room.

Once all participants returned to the main room, the event moderator asked for each small group spokesperson to share their group's key discussion point with the large group. Prior to ending the session, a link to a satisfaction survey (details are provided below) was placed in the chat box and participants were asked to take a few minutes to complete the survey.

Table 3. Zoom Session Sample Timeline

Timing	Activity
9:45 to 10:00	Listening Session Begins: Participant Arrival
10:05	Welcome by the IPH Event Moderator and Introduction of BHS Director
10:10	Overview of Session Purpose, Use, and What to Expect by the IPH Event Moderator
10:15	Participants placed in Breakout Rooms with Facilitators
10:15	Phone Participants Remain in Main Room for Discussion with the IPH Event Moderator
10:15 to 10:50	Breakout Room Participant Welcome, Introductions, Discussion, and Spokesperson Chosen
10:50 to 11:30	Breakout Room Spokespeople Share Out to Group
11:30	Closing Remarks and Thank You by the IPH Event Moderator, Participants receive link to satisfaction survey

Focus Groups

At each of the focus group sessions, after registration was complete, staff facilitators welcomed participants, solicited a brief round of introductions, informed attendees about the purpose, structure, and timeline for the discussion, as well as the topics that would be discussed. The facilitators assured participants that their feedback would be incorporated into a comprehensive report for BHS. Finally, the facilitators offered assurance that their feedback would remain anonymous. Facilitators for sessions with groups designed for specific racial/ethnic backgrounds were from the targeted communities. Facilitators for the focus groups for LatinX individuals were bi-lingual in Spanish and English. At least two IPH staff were present at each focus group; one to lead the conversations and one to take notes and monitor the chat. A semi-structured approach to focus group facilitation was employed. The pre-determined focus group questions were utilized, but facilitators allowed for a more conversational approach to the group so that participants could discuss issues of importance to them.

One-on-One Interviews

In addition to listening sessions and focus groups, community feedback about behavioral health needs in San Diego was gathered via interviews with people who requested them and targeted key informant interviews. These interviews lasted between 30 minutes and two hours. As with focus groups, these interviews were conducted in a semi-structured manner using the pre-determined discussion questions but allowing for natural conversation to evolve as well.

Interpretive services

Interpretive services were available by request for all Community Listening Sessions and Focus Groups. Spanish and Arabic language translation were each requested once for the Family and Youth Community Listening Session.

Evaluation

Evaluation of the engagement process occurred in two ways. First, so that the process could evolve as it unfolded, after each listening session and focus group, staff met to discuss the ways in which the process could be improved. Second, every participant was asked to complete a satisfaction survey when the event concluded. This information can be used to plan for future community engagements.

Debriefing and Modifications

At the conclusion of each listening session and focus group, IPH staff held a debriefing session with all staff to discuss what worked well and what needed to be modified. The IPH staff also reviewed satisfaction survey results after each session and met before each subsequent event to make improvements to the process. A team huddle was held prior to each session with all

IPH staff and facilitators to explain any modifications made. For example, the amount of time spent in small group discussions was shortened and waiting room procedures were modified to allow faster participant entry into the event. In this way, the events were continuously improved throughout the engagement process.

Satisfaction and Demographic Survey

In collaboration with BHS, the IPH created a satisfaction and demographic survey (see Appendix 8) during the 2019/2020 engagement year. This combined survey was divided into two surveys for the 2020/2021 engagement process due to the virtual nature of this year's engagement efforts. Participants were required to complete the demographic portion of the survey at the time of registration, and a link to the satisfaction survey was provided to each participant at the end of each listening session, focus group discussion, or interview. Participants were asked about their overall satisfaction with the event, the convenience of the event format and the day and time chosen, the relevance of the topics discussed, and how they learned about the event. They were also provided a space in which to provide suggestions for improvement.

IPH staff emphasized the importance of the participants' honest input about the process. In addition to providing a link to the survey, within an hour of the end of each session an email was sent to each participant to thank them for attending that included the link to the survey. A reminder email about the survey was then sent again several days later. Results of the satisfaction survey are presented in the concluding section of this report.

Data Analysis

Demographic information about participants was recorded in the registration form on Qualtrics. This information, along with the data from the satisfaction survey, was analyzed using SPSS (v26). A summary of participant demographics is presented in the Results section. It should be noted that data are incomplete; some participants did not register, and therefore, did not give demographic information. Others did not complete the entire demographic survey. Satisfaction survey results can be found in the final section of this report.

All ideas generated at the listening sessions, focus groups, and interviews were documented by facilitators. This information, along with the ideas suggested via chat in each Zoom breakout room, was then sent to the IPH Research Associates. IPH staff performed content analysis of these data using an iterative process combining deductive and inductive methods. Coding categories were discussed and finalized by three separate data analysts. Findings and themes were also independently verified by these analysts.

RESULTS

Participants

> ***"Trauma is very hard to talk about for quite some time after it occurs. At a biological level, Broca's area is inhibited, which makes it hard to think and put words together when you are experiencing trauma."***
>
> **– Interview Participant**

Total attendance at this year's engagement events was slightly lower than in past years. This was in part due to a strategic decision to conduct more focused and targeted recruitment of participants. In addition, when IPH staff had an opportunity to query people who had registered for an event but did not attend (people with whom, for example, past relationships had been cultivated or with whom IPH staff conducted interviews), they often remarked that they felt it would be too difficult – both practically and emotionally -- to discuss how they were doing. Some reported that they did not have the time to participate. Others reported that they were overwhelmed with trying to survive, too stressed to speak calmly, or felt that because they were in crisis mode, they had not yet had time to process their feelings. In an interview with a provider who performs county-wide training on mental health, the provider noted that their experience has been similar – that only about a quarter of people who sign up for their training sessions have been coming. This provider noted that, in addition to high levels of stress, it is challenging for people who are undergoing trauma to discuss it in part because of the biological processes at play.

The engagement events occurred during the most severe COVID-19 outbreak (surge) in San Diego County. Despite this and other unforeseen barriers to participation, the combined total of attendees at all events was 201. Details about attendees at each type of event are provided in Table 4 below. The table includes the number of people who registered to participate and the number who attended for both the community listening sessions and focus groups. For interviews, the table includes the number of people who expressed interest in an interview and the number who participated in an interview.

Table 4. Participants in Community Engagement Events

Targeted Audience	Date	Registered/ Expressed Interest	Participated
Community Listening Sessions			
Behavioral Health Service Providers	December 1, 2020	164	113

Family and Youth and Other Community Members	December 12, 2020	129	45
Subtotal		**293**	**158**
Interviews			
Requested Follow-up and Targeted Key Informant Interviews	Dec 2020 thru Feb 2021	16	10
Subtotal		**16**	**10**
Focus Groups			
Trauma Informed Guide Team	November 12, 2020	9	6
LatinX Individuals #1	November 18, 2020	15	6
API Individuals	November 21, 2020	6	0
LatinX Individuals # 2	December 2, 2020	16	2
Behavioral Health Service Provider Essential Workers	December 3, 2020	15	2
Loved Ones of Those with SMI	December 5, 2020	12	1
African American Individuals	December 8, 2020	17	3
People Receiving Services for a Serious Mental Illness	December 8, 2020	15	4
Loved Ones of People with Substance Use Disorders	December 15, 2020	12	4
Individuals with Substance Use Disorders	December 17, 2020	14	0
Rural San Diego/Mtn Empire	December 29, 2020	8	5
Subtotal		**139**	**33**
Total of All Events		**448**	**201**

* For Community Listening Sessions and Focus Groups, registration was required in order to receive a Zoom link; however, several people came who had not registered. All attendees at all groups were offered interviews, and outreach was also conducted to solicit interviewees. Interviewees were not required to register in advance. Some people attended more than one event. This table represents total number of attendees, not unduplicated participants.

As part of the registration process, participants were asked to provide demographic information. Some participants did not respond to all questions, and some people who attended did not register, resulting in varied sample sizes in the data summarized below. No demographic information was provided by 25 participants.

Demographic information collected included: age group, race, ethnicity, primary language used, sexual orientation, domain of disabilities, veteran status, assigned sex at birth, current gender identity, identification with selected special populations, and ZIP code.

Of the participants who provided demographic information, the majority were between the ages of 25-59 years old (65%), identified as White (60%), spoke English as their primary language (88%), identified their sexual orientation as straight (76%), did not have a disability (89%), were not veterans (95%), were assigned female gender at birth (74%), and currently identified as female (73%). Youth younger than 18 years old were invited to attend one community listening session and had to receive parental consent to do so; for all other events, participants were required to be at least 18 years old.

Table 5. Participant Age Groups

Age Group	Total n	%
0-15 years old	7	4%
16-25 years old	17	10%
25-59 years old	114	65%
60 years old or over	32	18%
Declined to answer	6	3%
Total	**176**	

Totals may not sum to 100% due to rounding.

Table 6. Participant Race

Race	Total n	%
American Indian or Alaska Native	2	1%
Asian	17	10%
Black or African American	10	6%
Native Hawaiian or Other Pacific Islander	1	1%
White	104	60%
Other	12	7%
More than one race	8	5%
Declined to answer	18	10%
Total	**172**	

Totals may not sum to 100% due to rounding.

Table 7. Participant Ethnicity

Ethnicity	Total n	%
Hispanic or Latino	**49**	**30%**

Ethnicity	Total n	%
Caribbean	0	0%
Central American	2	1%
Mexican/Mexican American/Chicano	23	14%
Puerto Rican	0	0%
South American	2	1%
Other	0	0%
Non-Hispanic or Non-Latino	**88**	**53%**
African	5	3%
Asian Indian/South Asian	5	3%
Cambodian	0	0%
Chinese	2	1%
Eastern European	4	2%
European	32	19%
Filipino	5	3%
Japanese	0	0%
Korean	1	1%
Middle Eastern	0	0%
Vietnamese	1	1%
Other[1]	1	1%
More than one ethnicity	**9**	**5%**
Declined to answer	**20**	**12%**
Total	**166**	

[1]Other response: a specific ethnicity was not provided.

Totals may not sum to 100% due to rounding.

Table 8. Participant Primary Language

Primary Language	Total n	%
English	155	88%
Spanish	18	10%
Tagalog	1	1%
Vietnamese	1	1%
Other[1]	1	1%
Total	**176**	

. [1]Other response included: Burmese.

Totals may not sum to 100% due to rounding.

Table 9. Participant Sexual Orientation

Sexual Orientation	Total n	%
Gay or Lesbian	10	6%
Straight or Heterosexual	129	76%
Bisexual	3	2%
Queer	5	3%
Another sexual orientation	1	1%
Declined to answer	22	13%
Total	**170**	

Totals may not sum to 100% due to rounding.

Table 10. Participant Disability Status (n=160)

Do You Have a Disability?	Totaln	%
Yes	**9**	**5%**
If yes[1]		
Communication domain: Difficulty seeing	1	1%
Communication domain: Difficulty hearing, or having speech understood	0	0%
Communication domain: Other	0	0%
Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)	5	3%
Physical/mobility domain	3	2%
Chronic health condition (including, but not limited to, chronic pain)	4	2%
Other[2]	1	1%
No	**156**	**89%**
Declined to answer	**11**	**6%**
Total	**176**	

[1]Multiple responses to specify disabilities.

[2]Other response included: epilepsy (n=1)

Totals may not sum to 100% due to rounding.

Table 11. Participant Veteran Status

Are You a Veteran?	Total n	%
Yes	2	1%
No	166	95%
Declined to answer	6	4%

Total	**174**	

Totals may not sum to 100% due to rounding.

Table 12. Participant Sex at Birth

Sex at Birth	Total n	%
Male	36	20%
Female	131	74%
Other	0	0%
Declined to answer	9	5%
Total	**176**	

Totals may not sum to 100% due to rounding.

Table 13. Participant Current Gender Identity

Current Gender Identity	Total n	%
Male	36	20%
Female	129	73%
Transgender	0	0%
Genderqueer	1	1%
Questioning or unsure of gender identity	0	0%
Another gender identity	0	0%
Declined to answer	10	6%
Total	**176**	

Totals may not sum to 100% due to rounding.

Participants were asked whether they identified with any listed special populations and each registrant could choose as many categories as were applicable. The number and total percentage of people who identified with each group is listed in Table 14 below. Of note, 60% of attendees identified as community members, consumers/clients, or family member of a consumer.

Table 14. Participant Special Population Groups Multiple Responses Question

Special Population Groups	Total n	%
Community Member	70	40%
Consumer/Client	15	9%
Family Member of Consumer	19	11%

Law Enforcement	0	0%
School Personnel	15	9%
Provider	108	62%
Immigrant	11	6%
Refugee/Newcomer	5	3%
Asylee	2	1%
Veterans/Military	6	3%
Homeless	5	3%
African	0	0%
Chaldean	1	1%
LGBTQI	15	9%
None of the Above	19	11%
Total Respondents	**175**	

[1]Percentages and totals are based on respondents.

Registrants were also asked to provide their ZIP codes, which were then grouped into six San Diego County HHSA-defined regions. The number and proportion of participants from each region is provided in Table 15. The Central and North Central regions had the most representation, followed by North Inland, East, South, and North Coastal regions.

Table 15. Event Participant Region

Region	Total n	%
Central	51	31%
North Central	40	24%
North Inland	26	16%
East	24	14%
South	21	13%
North Coastal	9	5%
Total	**166**	

[1]Percentages and totals are based on respondents.

Targeted Groups

Demographic information divided by event is provided in Appendix 9. Interestingly, while attendees at the listening groups appeared to align with the targets, this was not always true at focus groups. For example, 82% of attendees at the listening session for behavioral health care providers identified themselves as providers, while only 16% identified as providers at the

listening session for families and youth. Those who attended focus groups expressed an interest in the well-being of the groups targeted for the focus group but were not always from those groups. For instance, only 50% of people who came to the focus groups that were centered on the LatinX community identified as Hispanic or Latino.

Interviews were conducted with anyone who requested them. In addition, to ensure that feedback was gathered from groups not well-represented at the events, the IPH reached out to organizations and suggested community leaders to schedule interviews. Of the 11 interviews, three were with African American individuals, three were with Asian American/Pacific Islander individuals, two were the loved ones of people with serious mental illness, one was with an individual receiving services for serious mental illness (the interviewee's mother was also on this call), and one was with a loved one of a person with a substance use disorder.

Findings

Community participants were asked to discuss three primary topics: (1) what are the most serious mental health issues affecting the community right now and how has the pandemic, and other crises, such as recent instances of racial injustice, affected the mental health of people in the community?; (2) What are the most serious substance use issues in your community and how have the pandemic, and other crises, such as recent instances of racial injustice affected the substance use issues of people in the community?; and (3) What do you need to make sure you/your family come out of the recent crises stronger than ever? Or What should BHS be thinking about as they move forward with program planning to address the identified issues? Details about questions and discussion prompts for the events can be found in Figure 1 and Appendix 1.

Before describing the details of the findings of this year's community engagement, it is important to convey the tone of the conversations at the engagement events. Many participants expressed deep concern and about their own circumstances or the circumstances of their clients or loved ones. The engagement events occurred during the height of a COVID-19 surge. The situations, participants said, require immediate, effective intervention. There was an urgency to the discussions that was uncommon during the past two years for which the IPH has facilitated events.

Another notable difference in terms of content was that, in past years, the conversations tended to have different areas of emphasis depending upon the target audience and type of engagement event. This year, however, findings that emerged were remarkably similar across all engagement events and all participants.

The findings below are divided into two main sections. The first describes how the community views the current behavioral health of San Diegans – ultimately, as a crisis. The second

describes the solutions and interventions the community believes are necessary to address this crisis.

The Behavioral Health Crisis

Five findings emerged out of the analysis of conversations related to the behavioral health problems of San Diegans. These include:

- Finding 1: The behavioral health of the community has deteriorated and represents a crisis.
- Finding 2: More people are suffering from anxiety and depression and mental health issues have been exacerbated.
- Finding 3: The community is experiencing worsening substance use issues, including increased usage, relapses, and overdoses.
- Finding 4: The behavioral health of certain populations has been more severely impacted by the pandemic and instances of racial injustice.
- Finding 5: The worst is yet to come.

Finding One: The behavioral health of the community is deteriorating and represents a crisis.

Although some of the discussions in this year's engagement focused specifically on the ways in which mental health or substance use had worsened (discussed below), more so than in previous years, the conversations tended to be more broadly focused on the overall behavioral health of the community and the underlying causes of the deterioration in the community's well-being. The consensus across events was that the community is in crisis; as discussed below in Finding 5, the feeling was also that the worst is yet to come.

Participants noted that the community was suffering for many reasons; the general feeling was that it was not only the COVID-19 pandemic itself or specific instances of racial injustice that caused the deterioration. Rather, these crises also highlighted and magnified existing systemic, ubiquitous problems.

Community members shared seven key concerns related to behavioral health that have been created, exacerbated, or highlighted by both the COVID-19 pandemic and episodes of racial injustice. These include: (1) lack of preparedness in the community to function effectively in a time of crisis; (2) differential access to and effectiveness of education and care; (3) inadequate means to assess needs; (4) overwhelming and unmanageable negative feelings; (5) inability to meet basic survival needs; (6) decrease in utilization of behavioral health care services; and (7) an increase in overt, obvious racism and inequities.

Lack of preparedness:

> ***"Behavioral health service providers did not receive training on best practices for virtual service provision, so they are trying to replicate in person services, and this is often unsuccessful."***
>
> **- Behavioral Health Provider Community Listening Session Participant**

A common theme at this year's engagement events was that individuals, governmental organizations, and community-based organizations were not prepared to function effectively during times of extreme crisis. Community members noted systemic failures that left San Diegans without the resources they needed to function. This includes the provision of effective education for youth, resources for the most vulnerable populations, including the homeless, and in offering effective behavioral health resources. The community expressed gratitude and admiration for how quickly teachers, health care providers, and behavioral health care providers were able to implement and transition to offering virtual services but noted that most people – providers, educators, and individuals in the community alike – were not prepared to use these virtual systems and had to learn them quickly. This, in turn, created inequitable service provision and service utilization and left some without access to education and care.

> ***"The library offers a slice of dignity, and we pulled the rug out from under them without a replacement."***
>
> **– Focus Group Participant**

A key topic of conversation was about the failure to project and compensate for the consequences of closure of services for exceptionally vulnerable populations. Closing the libraries, for example, meant that many homeless individuals would not have access to shelter, bathroom facilities, and internet during daytime hours. The cessation of in person substance use disorder meetings left those most at risk for relapse without proper support. And, of course, the closure of schools left many youth without a vital safety net for behavioral health monitoring and assistance and families without vital resources for food and childcare.

Differential access to and effectiveness of education and care:

Community members noted that, for some, virtual education and telehealth behavioral health care works well, and for a small segment of people, virtual services may in fact be more desirable and/or reduce barriers to care.

Participants felt, however, that for most of the population, particularly those who are more vulnerable, access to programs, services, and education has been challenging and/or that the services are ineffective in meeting their individual needs.

> ***"People are giving up. They're not calling back. It's hard to be motivated to participate in treatment when they're not seeing providers in person."***
>
> **- Behavioral Health Provider Community Listening Session Participant**

Community members noted that even before the pandemic, there were too few easy to access, low cost and free behavioral health services, that non-English speaking community members could seldom find services in their native language, and that affordable, convenient transportation to services represented a significant barrier for many people. These barriers, they asserted, have been exacerbated by the pandemic.

> ***"Nothing can replace human touch. Zoom is not the same."***
>
> **- Focus Group Participant**

For those people without reliable internet service and devices compatible with virtual services, for example, access to services became impossible. Similarly, for those people who are not "tech-savvy," figuring out how to participate in services is a significant challenge. Providers noted that assessing clients on a virtual format can be difficult.

Many people noted serious concerns about privacy and confidentiality over virtual formats or do not have a private place in their homes to participate in services. Some people expressed embarrassment that their providers could see their living environments. People in recovery for substance use disorders were frequently noted to be hesitant to participate in services and programs online. Some expressed discomfort because online formats reduce the anonymity that is important to them because they could not confirm that only those known to them were participating in the session.

> ***"Not physically seeing people is hard. Not having these physical hugs. Virtual only goes so far."***
>
> **– Family & Youth Community Listening Session Participant**

Most participants felt that both education for youth and behavioral health services and programs are less effective in a virtual format. Clients and providers expressed a desire for miss the human connection that is essential to recovery and is difficult to cultivate online.

Inadequate means to assess needs:

> ***"Everywhere we look, we see suffering."***
>
> **– Focus Group Participant**

Participants expressed great concern about "hidden victims" in the pandemic. Without the safety net of regular contact with teachers and service providers, dysfunction and trauma in the home have become more hidden, they said, and it is harder for victims of violence to safely find support. In addition, the forced isolation has created "cohabitation stress" for families, leading, for some, to toxic home environments with no means of escape. Participants felt that there was no systemic way to assess the needs of people who are at risk for violence in the home, and that the increased stress of the pandemic, racial injustice, job loss, and financial insecurity has likely led to increased violence with decreased access to support and care.

> ***"Their lives were a secret before and now it's even worse."***
>
> **– Interview Participant**

Providers pointed out that schools are the largest referral source for outpatient care for traumatized children, and they are worried about unseen victims of child abuse and neglect. Community members and providers alike reported a belief that children are more often witnessing domestic violence.

> ***"Educators are the purveyors of hope, encouraging students to plan for the future. The current feeling is one of hopelessness, and students have lost that connection with their teachers."***
>
> **- Focus Group Participant**

The shelter in place orders to control the pandemic, it was reported, have been devastating for victims of domestic violence. Staff from the domestic violence crisis hotline described desperate calls for help but less space in shelters that are not allowed to "double up" because of safety precautions. When victims can secure a spot in a shelter, the shelters sometimes have inadequate Wi-Fi for children to use for schooling. In summary, violence in the home was perceived as on the rise, victims are more hidden than before, it has become more complicated for people to get help, and available resources have become scarce, according to community responses.

Overwhelming and unmanageable negative feelings:

At every engagement event, participants described themselves, their loved ones, and in the case of providers, their clients, as trying to cope with intense feelings of grief, isolation, loneliness, fear, uncertainty, and anger. These feelings often become overwhelming and contribute to deteriorating behavioral health.

> ***"Our safe havens have been taken away."***
>
> **- Interview Participant**

> ***"This whole pandemic is about grief."***
>
> **– Behavioral Health Provider Community Listening Session Participant**

In addition, many of the tools that people use to cope with and mitigate these feelings were not accessible. For many who have lost loved ones to COVID-19, for example, it was impossible to say good-bye in person before the loved one died, and then impossible, again, to remember the loved one and to be comforted by the rituals of memorial services. Grieving has become even lonelier.

Family and community events – weddings, religious celebrations, get-togethers – provide people with companionship and with hope during difficult times, and the loss of these activities, community members reported, has been significant. Places like libraries, churches, recreation centers, and other community havens were places where people go to feel better and to be feel a sense of belonging. Their closures have been difficult for the community.

> ***"I worry that people are losing their resiliency."***
>
> **– Focus Group Participant**

Inability to meet basic survival needs:

In interviews, focus groups, and listening sessions, contributors spoke frequently of the necessity of prioritizing basic survival needs over behavioral health needs. They pointed out that many families cannot take care of their own, or their children's, mental health, or substance use issues because they are struggling and often unable to meet their basic needs for employment, housing, food, and health care. Behavioral health cannot be addressed adequately without ensuring people's basic survival needs, including job loss, food insecurity, and eviction. Providers noted that many of their sessions ended up focusing on financial and employment worries, and, they said, they felt inadequately equipped to help their clients meet these needs.

> ***"Clients are bringing what's going on in the country and in the world into their therapy more than any other time in the past. They are also discussing needs like housing – this can dominate the sessions. We need better training on how to talk about these topics."***
>
> **– Focus Group Participant**

Decrease in utilization of behavioral health care services:

County data indicate, and providers concur, that behavioral health care services are being utilized less frequently during a time in which they are more needed than ever. Attendees at engagement events noted that the decrease in utilization has several underlying reasons: (1) people are focused on survival and are not focused on behavioral health; (2) some people dislike, do not trust, or do not have access to telehealth services; (3) parents are providing their own childcare and trying to oversee virtual education while also working and simply do not have the time to participate in behavioral health services; and (4) the lack of privacy in homes prohibits some people from participation in services. This decrease in the utilization of services exacerbates existing and emerging behavioral health issues.

> ***"People in our communities cannot even begin to think about behavioral health issues if they are more worried about where their next meal is going to be coming from. They have to focus on their basic needs."***
>
> **- Family and Youth Community Listening Session Participant**

More overt and obvious racism and inequity:

Community members were expressed that they see growing inequity and more overt racism in their communities. They noted that disparities in the rate of infection and death from COVID-

19, a continuous onslaught of instantly viewable acts of police brutality against people of color, and increased social acceptability of racist remarks and acts have contributed both to worsening behavioral health and a growing mistrust of governmental and community organizations.

Participants discussed how the higher rates of COVID-19 infection and death among communities of color, particularly the LatinX community, will inevitably lead to worsening behavioral health. These communities are simultaneously grieving the loss of loved ones and reeling from high rates of unemployment and from the need to perform essential work that places them at risk. For those who are undocumented, fear of deportation has kept them from receiving necessary healthcare and behavioral health care services. Community members highlighted the underlying systemic racism that has contributed to these disparate rates of infection and death and emphasized the need to address this type of racism. They also discussed the need to meet the basic needs of people in these communities so that they can stay at home when they have symptoms of COVID-19 or after they have been diagnosed to protect their own health and the health of the community.

> ***"We need to go after the source of inequities and that is the historical and current systemic racism that leads to these inequitable situations that harm communities of color the most."***
>
> **– Interview Participant**

Racial injustice, particularly instances of police brutality, is more easily and frequently witnessed because of online videos. While this, the community noted, has allowed for more awareness of racism, it has been traumatic to witness. In addition, among communities of color, mistrust of the County, of other governmental organizations, and of behavioral health providers has grown. Black individuals participating in the engagement activities described being afraid to report domestic violence to the police because they feared for the lives of the people involved if the police were called. Asylum seekers reported that the instances of police brutality were triggering for them – bringing up the traumas they experienced in their countries of origin and caused them to question whether they would find safety in the United States. Community members also noted that racism and racist acts seem to have become more socially acceptable.

This mistrust is deepened by the lack of adequate representation of people of color, particularly immigrants, at the County and among behavioral health providers, community members reported. This mistrust, in

> ***"People need more intervention than in the past, now!"***
>
> **- Interview Participant**

turn, leads to hesitancy among some groups to participate in behavioral health services. One interviewee noted, for example, that people of color are reluctant to get behavioral health care for their children because they worry that their children will be labeled with a psychiatric disorder and/or will be medicated. The community also expressed frequent frustration that while cultural competency is often discussed as a goal for BHS, racism is seldom addressed directly. Teens reported that they are ready for and want to have genuine conversations about racism.

Finding 2: More people are suffering from anxiety and depression and mental health issues have been exacerbated.

> ***"People are buried in anxiety right now."***
>
> **– Focus Group Participant**

At all engagement events, attendees reported that more people seem to be suffering from anxiety and depression. Some pointed to fear and uncertainty about the pandemic as being the primary cause; some said that enforced isolation is causing depression; others suggested that racial injustice was contributing, while still others discussed the negative impact of the inevitable rise in "screen time" on youth. For those who had existing struggles with mental health, the acuity of their needs is worsening, while at the same time, their ability to access help is lessening. Providers reported that in-patient psychiatric beds are full, leaving many without a place to go during a mental health emergency. For some people with mental illness that includes a component of paranoia, COVID-19 has aggravated this problem. Mask wearing was pointed to as particularly difficult for people suffering from paranoia – it is challenging for them to see people in masks and to be told they must wear a mask.

> ***"The opposite of addiction is connection."***
>
> **- Interview Participant**

Finding 3: The community is experiencing worsening substance use issues, including increased usage, relapses, and overdoses.

Community members and providers expressed a belief that substance use is increasing. More people are using drugs and alcohol, they said, often as a means of coping with the fear, loneliness, grief, uncertainty, and anxiety caused by the pandemic. While some believe youth are using substances less often because they spend more time at home, others believe that youth are accessing substances in their parents' medicine cabinets, are making their own drugs out of cleaning supplies, or are newly experimenting with different

> ***"If you live in a neighborhood without life-affirming resources, liquor stores and dispensaries become very tempting."***
>
> **- Behavioral Health Provider Community Listening Session Participant**

substances to help manage the stress of the current circumstances. Dispensaries have remained opened, cited as essential businesses, which, the community argued, has contributed to the normalization of marijuana use among youth, and youth are using high-potency THC products and edibles without understanding the potential risks. Parents, they reported, are more often using in front of their children now.

> ***"I'm really worried about my friends who use. They're vaping and smoking weed, and they won't talk about it."***
>
> **- Family and Youth Community Listening Session Participant**

Another concern was that people are drinking more alcohol than they were before the pandemic. Individuals have easy access to alcohol, particularly through delivery services, which do not always check to make sure people are of age. In addition, liquor stores have remained open, even during periods of shut-downs, and restaurants are offering to-go alcoholic beverages.

Engagement attendees also discussed the prevalence of fentanyl, both as an added ingredient to other drugs, and as a drug that is now sometimes used on its own. Fentanyl, they report, is often sold as oxycontin. The community also observes increased usage of methamphetamine. And while these concerns are not new, they said, participants felt that while COVID-19 is at the forefront of public health interventions, there seems to be little support or funding around these issues.

> ***"People in recovery have told me 'COVID is going to kill me anyway, so I might as well use.'"***
>
> **- Focus Group Participant**

> ***"People started to have relapses when the lockdown started because their support disappeared. Then many programs they need, like housing, kicked them out because of their relapses. Now, they are homeless during a pandemic, and it becomes an endless cycle – a spiraling pattern."***
>
> **-Behavioral Health Provider Community Listening Session Participant**

Overdoses, attendees reported, are also more common. This is in part because, for many people in recovery, virtual treatment and support is undesirable and ineffective. Relapses are occurring, and along with them, as people return to previous levels of drug use that their bodies can no longer tolerate, overdoses are happening. Too few people have Narcan on hand and/or know how to use it to reverse the effects of an opioid overdose.

In addition, treatment facilities have become even more challenging to access, particularly for those who are uninsured. Some are hesitant to go to treatment facilities even when they are available, out of fear of contracting COVID-19. Detox facilities, specifically, are scarce. Emergency departments cannot admit people who want to detox if there's no current medical necessity; so, if someone wants to detox voluntarily, and there are no beds available, which is common. They must wait until their life is in danger to receive care. As a result, even though people in recovery know that is potentially dangerous to detox from drugs or alcohol without medical support, they try do it at home.

Finding 4: The behavioral health of certain populations has been more severely impacted by the pandemic and instances of racial injustice.

While the entire community has been affected by the recent crises, certain populations were described as more severely impacted than others. This includes: (1) Black, Indigenous, and People of Color; (2) immigrants and refugees; (3) youth; (4) parents; (5) foster youth, foster parents, and biological parents involved in juvenile dependency court; (6) people with existing behavioral health issues; (7) seniors and aging adults; (8) people living in rural areas; (9) essential workers; and (10) behavioral health providers.

Black, Indigenous, and People of Color (BIPOC):

In San Diego County, LatinX individuals have had devastating rates of infection and death from COVID-19. The grief from these losses, combined with fear of the illness and serious financial and other stressors, has caused both anxiety and depression in this community. In addition, the community explained, for many LatinX individuals, seeking help for a behavioral health concern is challenging for a number of reasons, including: lack of access due to being uninsured and lacking the financial means to pay for care, lack of access due to the unavailability of linguistically and culturally appropriate care, for those who are undocumented, fear of deportation and the inability to take time off of work, the prioritization of family members' needs over one's own needs, and, finally, the stigma attached to admitting to having and seeking help for a behavioral health need.

> ***"When he was yelling, 'I can't breathe,' well, we can relate to that. We have felt that."***
>
> **- Focus Group Participant**

For Black individuals, the past year has been traumatic not only due to fears related to the pandemic and the enforced isolation but also because of numerous instances of violence against Black people, particularly incidents of police brutality. In addition, community members described encountering more overt racism and a feeling that racist acts have become more socially acceptable. Black individuals are suffering from behavioral health issues due to these traumas, but may also, participants said, have feelings of deep mistrust toward care providers due the long history of mistreatment in the healthcare system. This mistrust is intense enough that they are extremely hesitant to seek out help.

> ***"Black families worry that their children will be labeled, categorized, and medicated if they seek out help for them, and that this will mess them up even more. Their children already face unfair discipline in schools. What will happen if the school knows that they have a diagnosis or take medication?"***
>
> **- Interview Participant**

The Indigenous people of San Diego have also been severely impacted by the pandemic in terms of accessibility to school and behavioral health resources. Participants noted that on many reservations, internet, especially Wi-Fi is not reliable, rendering school for youth and access to telehealth for everyone, particularly difficult.

> ***"I was in the Costco parking lot, and a man in a car nearly ran me over, yelling 'go back to your own country and take your virus with you.'"***
>
> **- Interview Participant**

Asian Americans described being fearful out in public because of a rise in racist attacks, fueled by political rhetoric calling COVID-19 "the China virus" and the "Kung Flu." This has caused increase stress and anxiety on top of worrying about contracting the virus. Complicating the issue for Asian Americans, like some other groups, mental health is not commonly discussed openly. Privacy and stoicism are ingrained values, and the stigma attached to mental illness is strong.

Immigrants and refugees:

Immigrants and refugees, the community said, have been impacted by both the pandemic and instances of racial injustice in several ways. First, immigration hearings have been delayed, and in general, the immigration process has become more onerous. This has not only created anxiety for the

> ***"Representation is the most important thing."***
>
> **- Focus Group Participant**

people waiting to resolve their status, but it has also prohibited access to services needed due to status and cost: MediCal/Medicaid can only be accessed once cases have resolved.

Many reported that people from immigrant communities (the Hmong, Somali, and Filipino communities were specifically cited) are having a difficult time acquiring the resources needed to maintain their physical and mental health and feel safe during the pandemic. Language barriers were noted as one major barrier to accessing care. Navigating systems of care is complicated, participants noted, and for people new to the country, and for those who do not speak English, finding and receiving care without assistance is nearly impossible.

> ***"Mental health is a taboo subject in the Somali community."***
>
> **- Focus Group Participant**

The lack of representation among behavioral health care providers was discussed extensively. People need and want providers who come from their neighborhoods, speak their language, and understand their cultures. This need has been magnified during the pandemic and by heightened awareness of racial injustice, which has intensified some communities' mistrust of health services, especially mental health services.

In addition, in many immigrant communities, mental health and substance use issues are not openly discussed. A high value is placed on self-reliance and discipline; seeking care is considered a sign of weakness. There is shame, participants said, associated with admitting to being suicidal.

> ***"Kids have lost the ability to project themselves into the future; they are losing hope."***
>
> **- Interview Participant**

Youth:

Youth, parents, and behavioral health care providers all emphasized that for youth, the isolation necessitated by the pandemic has been particularly devastating. Online learning can be anxiety-provoking, youth reported, and leaves them feeling disconnected from their teachers and peers. It is difficult to go to school and study when everyone in a household is home, competing for space that allows for learning. Older siblings, youth told us, are often having the responsibility for their younger siblings' schooling while their parents work. Students who have disabilities, such as ADHD and those who have IEPs, are not getting the services they need. Mental health problems for youth also arise from and are exacerbated by isolation from friends

> ***"We have to remember that for a 10-year-old, COVID has taken up 10% of their life."***
>
> **- Focus Group Participant**

and the cessation of extracurricular activities. Students with behavioral health issues often receive their services onsite at their schools, and these services are no longer running.

Youth also discussed the impact of witnessing the murder of George Floyd and other incidents of police brutality. Being isolated at home, watching the videos alone, and having continual access to them, without the respite of school and activities, intensified the trauma of bearing witness to these events.

Parents:

> ***"To be pregnant in a COVID era is a mental health crisis to begin with. Add to that the financial toll, and it's mind-boggling."***
>
> **- Focus Group Participant**

Parents, too, are suffering, the community members reported. They have had to step into the role of managing their children's education while trying to maintain their employment. Some have had no choice but to leave their children home, unsupervised, while they go to work – issues related to childcare have been huge stressors. Parents reported worrying intensely about their children's physical and mental health. Pregnancy has also become a significant source of stress with concerns about contracting and transmitting COVID-19 to the unborn baby and about going to the hospital to deliver during a pandemic.

Seniors:

Many older adults, who are at highest risk for severe impacts of COVID-19, are lonely, anxious, and depressed. In addition, the community noted, many older adults struggle to use technology, limiting their access to virtual behavioral health services.

People with behavioral health issues:

The community described worsening conditions for people who had behavioral health issues before the pandemic started – conditions like depression are worse when combined with forced isolation. People with Post-Traumatic Stress Disorder, people who have survived torture, for example, are encountering triggers more often, providers said. Treatment is harder to access or less effective for many. For people with substance use disorders, structure is important, the community said. The loss of regular in-person meetings and support groups has caused people to relapse.

Foster youth, foster parents, and biological parents involved in the dependency system:

Juvenile dependency hearings have been postponed during the pandemic, which has caused delays in ensuring permanent living situations for foster children and stress for the youth as well as their foster and biological parents. In addition, foster parents have had to take on the

additional responsibility of managing at-home education. Providers report shortages in placements for foster youth, creating additional stress on the foster care system.

People living in rural areas:

> ***"It's challenging to be a young person living in a rural area. And now kids are feeling overwhelming disconnected."***
>
> **- Focus Group Participant**

The closures of schools and other resources is particularly impactful for people living in rural areas, the community explained. For youth, for example, because their friends often live far way, school was the only place to socialize. Parents in rural area relied on schools not just for education but also for food and other resources – schools serve as resource hubs in rural areas. In addition, internet is unreliable in many rural areas rendering virtual schooling nearly impossible.

Food insecurity has grown in rural areas, providers explained. Grocery stores are far way, food pantries are limited and often far away, and gas is expensive. Without the safety net of meal provision at school, many families are now food insecure. This has created intense stress and anxiety. On the other hand, alcohol and drugs have remained widely available in rural areas, offering a tempting way to cope with the stress.

People who live in rural areas, participants said, are proud of their self-reliance and their hard work to provide for their families. They do not want to be known as "charity cases," and may perceive offers of help – particularly from outsiders – as an insult; they are also often deeply mistrustful of governmental organizations. Because these tend to be smaller communities, it is also difficult to seek and receive resources confidentially, and the stigma associated with behavioral health services is strong.

Essential workers:

> ***"We are chewing up a ton of personnel."***
>
> **- Focus Group Participant**

Healthcare providers, teachers, grocery store personnel, restaurant workers, delivery drivers, and other essential workers are suffering from high rates of COVID-19 infection, job loss, and both primary and secondary trauma. Their behavioral health needs, the community emphasized, have not been prioritized, and these needs are profound. Participants predict shortages of people willing to work in these jobs in the future and massive departures from professions like teaching and nursing as these individuals try to care for their own health and well-being.

Behavioral health service providers:

> ***"We are suffering from compassion fatigue from this long arc of suffering."***
>
> **- Behavioral Healthcare Provider Community Listening Session Participant**

Behavioral health service providers were open and direct about their own needs during the focus groups and during the community listening session specifically targeted to behavioral health providers. They have, they reported, been trying to manage the increased intensity of their clients' needs without additional resources while adapting to new modes of service provision with little training or support. They are frustrated by what they perceive as their own lack of knowledge and skills to address issues like the pandemic and racism. They are spending more of their time in sessions trying to help their clients find resources for employment, housing, and food, which leaves little time for the discussion of behavioral health needs. Some clients with mild or moderate mental health symptoms who are supposed to be having brief treatment will not terminate because their sessions are the only significant connection they have, and this has contributed to growing caseloads. Providing coverage for co-workers who have COVID-19 has also increased the workload and caused worry and stress. They want to provide in-person services because they feel these are more effective, but they fear contracting COVID-19 from their clients. On top of all these work-related stresses, behavioral health providers are, of course, facing their own challenges – grieving lost loved ones, trying to care for sick family members, securing childcare, and monitoring their children's education. Behavioral health care providers, they emphasized, are experiencing high levels of secondary trauma, and this is negatively impacting their own well-being and their ability to effectively care for their clients.

> ***"I have a lot of stamina emotionally and physically, but this has been a lot."***
>
> **- Behavioral Healthcare Provider Interview Participant**

The Tsunami of Need

> ***"We need to prepare for the tsunami of need that is coming."***
>
> **- Family and Youth Community Listening Session Participant**

One of the points that community members and providers felt most important to convey during the engagement efforts is that the greatest behavioral health needs will be seen in the months and years after the pandemic has resolved. They noted that prevention efforts to ensure strong behavioral health and promote resiliency have necessarily become a lower priority. They pointed out that, while some people have suffered disproportionately compared to others, the entire population has experienced trauma, and the impacts of this cannot yet be known but are likely to include serious detriment to people's behavioral health. They also discussed that teachers and other school personnel, who themselves have undergone great stress, will face entire classrooms filled with traumatized students. Right now, they pointed out, people are focused on surviving; the true effects of this trauma will come to light once people are out of survival and response mode. They also noted that there is some protective value in the current collective nature of suffering. People have some sense that they are not alone in their suffering. This creates a sense of camaraderie that may dissipate once the immediate crisis has passed.

> ***"Right now, our suffering is held in a collective container. It helps us that we know we are not alone or unique in our pain. This sense of collectiveness will not always be us."***
>
> **- Interview Participant**

Addressing the Crisis: Actions Suggested by the Community

During each type of engagement event, the final discussion prompt was designed to query the community's thoughts and ideas for staying resilient and to inform BHS about ways to move forward in the face of the current crises. The ideas discussed can be grouped into ten actions the community recommends that BHS take:

1. Increase the use of peer mentors with lived experience.
2. Develop additional culturally, linguistically, and developmentally competent outreach and engagement efforts.
3. Develop community-based, community-designed, and community-staffed behavioral health services.
4. Recognize that basic needs and behavioral health needs are connected and integrate services to meet those needs.
5. Address racism.

6. Create school-based services and programs specifically for youth.
7. Provide professional development and offer more support to behavioral health providers.
8. Implement more non-traditional approaches to treating behavioral health issues.
9. Re-evaluate the substance use disorder continuum of care.
10. Create a comprehensive plan to address short term and long-term behavioral health impacts of current crises and to prepare for future crises.

Action One: Increase the use of peer mentors with lived experience.

One of the most frequently suggested interventions, mentioned at nearly every community engagement event, was to increase the use of peer mentors who are culturally matched with and have lived experience like that of the people they serve. The use of peer mentors, the community said, addresses several concerns. First, lack of trust was identified as a major reason why many communities, including youth, BIPOCs, immigrants, people living in rural areas, and people with substance use disorders hesitate to seek help and utilize services. The consensus was that community members are more likely to accept help when the services are delivered by someone from their community who speaks their language; language and can be ethnicity-specific like Spanish for people from the LatinX community or age-specific, like jargon used by teenage social media influencers. Similar lived experience can be validating and ensures that individuals will not feel judged or condemned for their behavioral health issues. Second, peer mentors may be more readily available and accessible over communication modes like text messages, whereas more "professional" behavioral health providers must often limit contact to a designated session time. They can take the time to form genuine connections and cultivate relationships. Third, peer mentors may be more connected within these communities and better equipped to help people find necessary resources, beyond behavioral health services. Peer mentors can help individuals build sustainable, meaningful systems of support. Fourth, because peer mentors are not required to

> ***"The way that people get help is to make a real connection. It takes time to build that relationship, but human interaction is everything. This is true for all of us. Create support systems for those who have few or none."***
>
> **– Focus Group Participant**

> ***"Our hope lies in seeing people who have gone through trauma themselves so that we know that if they can do it, we can do it."***
>
> **– Interview Participant**

have graduate degrees and licenses, it should be easier to find qualified candidates for these roles. It is also likely less expensive. Finally, peer mentoring was also a highly recommended strategy to reach youth who are more likely to listen to another youth rather than an adult expert.

According to community comments, BHS should recruit peer mentors from churches, schools, service groups, and grassroots organizations and could use evidence-based models like the Promotora model of patient navigation and health education to build their programs. Peer mentors should receive specialized training and ongoing support from licensed behavioral health experts. BHS should investigate, some suggested, implementing a certification program like those used in other states. Peer mentors can not only be a readily available, trusted means of support, but can also help link individuals to professional behavioral health services that are underutilized in their communities.

Action Two: Develop culturally, linguistically, and developmentally appropriate outreach and engagement efforts and deliver public health messaging through multiple methods.

Community members cited the need for people to be better educated – both about the pandemic and how to keep safe and about symptoms of and resources to address behavioral health issues. They also noted that too many people are not engaged with available services. More outreach and engagement need to be conducted and these efforts need to be tailored to specific populations and delivered to them through relevant methods. For example, messaging and services could be promoted according to the media consumption of the target groups: youth, the youth said, could be reached through Instagram or Snap Chat or via social media influencers, whereas the aging population might be better reached through the radio. Asian Americans, some reported, prefer less direct methods of outreach. Direct conversations or inquiries about behavioral health may be unwelcome to Asian Americans. Rather, an approach that offers easily accessible, widely distributed information in the right language that allows people to read it and process it on their own is far more likely to be successful. Even within the same ethnic group, messaging needs to vary; for example, what is relevant and meaningful for older immigrants will likely differ from what is relevant to the younger first- generation population. Messaging for immigrants could include reassurance about their documentation status so that those who are undocumented understand how they can safely receive services. In addition, ethnicities need to be disaggregated as much as possible

> ***"The real question is: how can we get the right information to the folks who need it?"***
>
> **- Behavioral Health Provider Community Listening Session Participant**

so that the messages are truly meaningful. For example, many different Asian groups live in San Diego, and their needs may also be different.

> ***"BHS could take a more proactive role to get into community meetings and other events to make sure people are educated."***
>
> **– Family and Youth Community Listening Session Participant**

In addition, for many people, it is important to hear directly from BHS, and community members expressed a desire to have BHS leadership attend community meetings in a variety of venues to help educate the public about behavioral health. Another common suggestion was for BHS to partner with religious leaders so that education and engagement can occur within religious institutions. Finally, participants commented that it is important to use more informal means of outreach by doing things like posting information about resources in places like grocery stores, thereby potentially reaching those who do not have internet service.

People need to understand what is happening with the pandemic, what recovery will look like as individuals and as communities, and what the potential behavioral health impacts are, according to participant comments. Because uncertainty is causing stress and anxiety, the public wants more information, delivered more frequently, in more ways. Parents need to better understand how they can help their children. Youth need to know ways they can connect with support that is meaningful to them.

> ***"It would be helpful to know what to expect in the future, what recovery will look like, what is getting back to normal and how will it look? The openings and shut-downs make it even more difficult, not knowing what to expect, having a lack of clear information, makes it worse."***
>
> **- Family and Youth Community Listening Session Participant**

Action Three: Develop community-based, community-designed, and community-staffed behavioral health services.

> ***"Communities require their own strategies to address behavioral health issues."***
>
> **– Behavioral Health Provider Community Listening Session Participant**

The pandemic has heightened recognition that too few safe havens to turn to in their own neighborhoods, according to participants. The closure of libraries, for instance, impacted many people and left them without a community hub. Behavioral health supports, programs, and services need to easily accessible within neighborhoods. They also need to be designed with the help of people living in those neighborhoods so that strategies are meaningful and to gain community buy-in to those services; this would lessen the stigma associated with seeking out services. Most importantly, the people who deliver the services must be representative of the people they are serving. This was emphasized multiple times by engagement participants. Community members commented that there are too few people that look like them, speak their language, and understand their neighborhoods and cultures working for BHS and in contracted programs. In-depth assessment of creative ways to engage and partner with smaller community-based programs and services that already have access and trust of underserved populations would be especially helpful, as would providing grassroots organizations with funds and training (e.g., teaching employees to write successful grant applications) to build their capacity.

> ***"Success starts with having people in the profession who have credibility in the community – so the narrative can be framed about 'these folks will help you, they understand our people, they won't label us.'"***
>
> **- Interview Participant**

> ***"The County must recruit a workforce that is representative of who is being served."***
>
> **– Focus Group Participant**

Action Four: Recognize that basic needs and behavioral health needs are connected and integrate services to meet those needs.

The COVID-19 pandemic has left many people unemployed and with unstable housing and uncertain food supplies. It has also exacerbated pre-existing vulnerabilities for those suffering from poverty, unemployment, homelessness, and food insecurity. A frequent theme at the engagement events was that it is impossible to separate basic needs from behavioral health needs – that, in fact, basic needs *are* behavioral health needs. Community members expressed a desire for comprehensive services in one place to meet all these needs.

> ***"We need to do a better job at coordinating and integrating care. "No wrong door" is a good idea, but it isn't currently happening."***
>
> **– Behavioral Health Care Provider Community Listening Session Participant**

Behavioral health providers expressed frustration about being unable to help their clients meet these basic needs and described sessions devoted to discussing these, rather than behavioral health, needs because their clients have been focused on basic survival. Financial and housing stability are crucial, as is access to affordable health insurance most agreed – it is impossible, they said, to effectively address mental health and substance use disorders without addressing poverty and housing. The current structure of services and resources in the County forces an individual to seek out resources for different needs from different organizations in different places – and this creates significant barriers for those with behavioral health problems. One specific suggestion was that BHS should partner with community-based organizations to offer neighborhood-based wrap-around services.

According to participant comments, the pandemic has rendered equitable access to internet services and computers or other devices a determinant of health. All community members need to have reliable technology and need to know how to use it. Universal Wi-fi access and training to help those who do not know how to use technology are crucial.

Action Five: Address racism.

> ***"No one wants to think about system racism. It's easier to just continue scapegoating certain groups."***
>
> **– Interview Participant**

Community engagement participants discussed a growing awareness of both health disparities and systemic racism in the community. Statistics related to the disproportionate rates of infection and death from COVID-19 among LatinX individuals and episodes of police brutality against Black people and the resulting protests have heightened awareness about inequalities and racism, they said. Many participants expressed frustration with the

indirect ways with which these issues are often discussed in the field of behavioral health; the use of the term "cultural competency," for instance was seen by some as an overused term that leads to few results. Youth expressed a desire to have conversations and programs that discuss racism directly, teach anti-racism, and create actions for everyone to take to combat racism.

> ***"We need more intentional hiring within BHS of individuals who are reflective of the clients they are serving."***
>
> **– Behavioral Health Service Provider Community Listening Session Participant**

Among providers, a desire was expressed for a "true assessment" of the structural racism that exists in local governmental and community organizations, including BHS. Providers and community members alike pointed to the lack of representation of some populations within BHS and among contracted providers as one example of subtle, but important, systemic racism.

Specific suggestions offered include:

- The County should conduct a full assessment of its own systems and address how they might be unknowingly perpetuating racism.
- The County should create and implement a sustainable plan to incorporate anti-racist practices at all levels of BHS.
- The County should plan to actively recruit, hire, and retain people from the communities they serve.
- All providers should receive training on how to understand historic and cultural trauma and their impacts on behavioral health as well as on anti-racist practices.
- Contractors with BHS should have to document and should be evaluated for how they incorporate anti-racist practices into their work.
- BHS should implement the recommendations from the Disparity Report the State published eight years ago.

Action Six: Create specific school-based care and services for youth.

Youth participants were often adamant that they need and want more education and support in school regarding behavioral health. Ideally, they said, this education would be designed and provided by youth themselves with the support of behavioral health professionals. Youth expressed concern about their own behavioral health and said that they often do not know how to help their friends when they are worried about them. Implementation of restorative practices at schools was cited a positive step. They articulated the view that when students exhibit behavioral problems, these often stem from struggles with mental health, meaning that that traditional punitive disciplinary practice does not help. Adaptation of restorative justice practices was cited as as a way of checking in and giving youth a place to talk about their well-being.

> ***"Instead of addressing root causes, we're punitive. We need to be more thoughtful about how to address substance use for youth. We're seeing more people use these as escape mechanisms. There's something deeper going on here."***
>
> **– Family and Youth Community Listening Session Participant**

> ***"Restorative practices are normally only for students who are having trouble in school, but I think they should be for everyone because even those who are doing well in school and don't get in trouble are also having a lot of issues in a lot of different aspects of their life. If you directly asked a youth a question, they'd answer honestly. It'd be beneficial for all of us."***
>
> **– Family and Youth Community Listening Session Participant**

A consensus view noted the importance of K-12 behavioral health education programs so that children start learning about mental health, substance use, and coping skills in an age-appropriate way as early as in Kindergarten. This education should also include opportunities for parent education and the promotion of resources to parents.

> ***"When kids start learning about their mental health from day one, then we're just one generation away from parents knowing how to handle mental health issues."***
>
> **– Interview Participant**

Educators also need to be trained so that they can adequately recognize and address mental health and substance abuse issues. One specific suggestion was to ensure that schools are all using a universal suicide assessment. Data collection about student well-being would also help inform future programming.

Action Seven: Provide professional development and offer more support to behavioral health providers.

Behavioral health service providers often expressed that they have been on the frontlines, trying to help people cope with the fall-out from the pandemic and from growing racial injustice. Participants described needing to immediately adapt their service provision to a telehealth mode without any prior knowledge of how to do so. They talked about their clients' needs being more acute, while resources being scarcer. For some, caseloads grew. Others worried about clients who no longer showed up for sessions. Participants expressed that they are experiencing high levels of secondary trauma and and need support. Providers need tools to combat burn-out and compassion fatigue and want training on how to talk through complex issues related to racism and the pandemic with their clients. They cited the need for further training on how to address adverse childhood experiences (ACEs), provide trauma-informed care, and adopt a life course approach to care. And, they said, they want to learn more about best practices for providing behavioral health services in a virtual mode.

Action Eight: Implement non-traditional approaches to behavioral health support.

Additional resources and support are needed to deal with the increased stress, anxiety, and depression that occur during crises, and traditional approaches are not always effective for people while in the throes of trauma, participants shared. In addition, non-traditional approaches to care may appeal to people for whom the stigma and shame attached to receiving behavioral health services keep them from seeking help. Community engagement participants said they want more variety in approaches to behavioral health care. Art and music therapy, organized nature walks, opportunities to hear motivational speakers, and safe ways to engage in community conversation were all suggested as ways to creatively prevent and address behavioral health issues. Non- verbal therapies, providers pointed out, can be good for people experiencing trauma, at least until they are ready and able to talk. Allowing for County reimbursement for more holistic approaches, providers said, should be considered.

> ***"Moments of community and encounter can be very healing. Community conversation is a remedy."***
>
> **– Interview Participant**

> ***"For some people to get a mental health diagnosis and to enter treatment is so shaming that it is better to think outside the box in terms of traditional assessment and intervention."***
>
> **– Interview Participant**

During several engagements, the role of law enforcement was also discussed. Participants feel that the traditional approach of relying on police officers to cope with people who are having a behavioral health crisis is unfair to both the officers and the people having the crises. Community members feels strongly expressed that BHS and law enforcement should work together to find ways to ensure that police are not responsible for managing behavioral health crises; the PERT team was discussed as one successful, but not yet far reaching enough, model.

> ***"When a person is clearly having a mental health problem, why are we having the police respond to it? Our social contract is that the police should respond, but this doesn't necessarily help anyone."***
>
> **– Behavioral Health Service Provider Community Listening Session Participant**

Action Nine: Re-evaluate the substance use disorder continuum of care.

Participants in the engagement events expressed that the pandemic and racial justice crises have caused increased substance use, relapses, and overdoses. Safety concerns related to the pandemic have simultaneously created barriers to providing and receiving consistent, effective substance use disorder treatment. Because of this, providers believe that this may be the ideal time to reevaluate the system of care for people with substance use disorders. Within that evaluation, participants pointed to several specific issues that need to be considered:

> ***"Now is the time to more carefully evaluate our continuum of care for SUD, to look at the weaknesses and the gaps. We are getting them to the trough and then there is nothing to drink."***
>
> **– Behavioral Health Service Provider Community Listening Session Participant**

- The number of immediately available detox beds for those who express an interest in withdrawing from alcohol or drugs.
- The availability and effectiveness of services for long-term methamphetamine users
- The monitoring of methadone clinics.
- The integration of Drug Medi-Cal and "regular" Medi-Cal.
- An assessment of whether substance use providers are using fentanyl testing in the most efficacious manner.

Providers advocated for the establishment of county-wide syringe service programs, the provision of fentanyl testing strips at locations across the county, and education and awareness about Narcan. They also discussed the challenges of coordinating care with emergency departments. Emergency departments, they said, are not supposed to and often do not have

the resources to help someone who comes to them wanting help with an acute or chronic substance use issue. At the same time, drug treatment and detoxification facilities often have no immediate availability. This leaves people who are ready to receive assistance without the kind of care they need – closing a window on an opportunity for intervention that may not occur again.

Finally, to address increasing substance use among youth, participants advocated for creating policies that ban flavored e-cigarettes and marijuana advertising, especially on billboards.

Action 10: Create a comprehensive plan to address short term and long-term behavioral health impacts of current crises and to prepare for future crises.

Participants expressed a strong belief that, as difficult as the current situation is for many people, in terms of behavioral health impacts, the worst is yet to come. Right now, they explained, people are in response mode – coping with immediate survival needs and doing the best they can from day to day. As the crises abate, the behavioral health impacts will begin to emerge: an entire population will have experienced at least some level of trauma. There is an immediate need to create a plan to address short-term and long-term behavioral health needs and to create a sustainable plan to address future crises. According to participants comments, element of planning should be addressed as follows.

> ***"Make a plan for the residual effects of the pandemic; support a one-to-two-year timeline to recover."***
>
> **– Behavioral Health Service Provider Community Listening Session Participant**

Short term planning:

The short-term plans should include: (1) strategies to help students, teachers, and other school personnel as schools re-open; (2) methods to safely resume the provision of in-person behavioral health services; and (3) strategies to support the behavioral health of essential workers, particularly behavioral health care providers.

Strategies for schools:

The community expressed concern over the transition of students back into regular school schedules. Teachers, they said, will be facing classrooms in which every child has been traumatized to some degree, while trying to cope with the traumas they have faced themselves. Students

> ***"When schools reopen, students and teachers are likely to experience anxiety from perceived loss of social skills, loss of friendships and connections, loss of academic skills, and fear about COVID"***
>
> **– Focus Group Participant**

may be behind academically and may struggle to re-integrate socially. Youth said that while they look forward to going back to school, they worry about what it will be like to have to cope with the daily stresses of school life. BHS should coordinate with the school districts to determine how to best care for students, teachers, and other school personnel during the process.

Strategies for in-person service provision:

Participants noted that it may be many months until a full return to "normal" is possible. Many expressed that behavioral health care, for most people, is more effective in person. Ideas for safe ways to return to in-person service provision should be considered, they said. Outdoor venues for therapy and rapid testing were two ideas suggested.

Strategies to support behavioral health service providers and other essential workers:

Expecting that the demand for behavioral health assessment and services will rise in coming months, participants emphasized the importance of taking care of behavioral health service providers, as well as other essential workers. BHS should work with their own and contracted providers to create systems of support to help behavioral health providers manage the impact of both primary and secondary trauma on their own behavioral health. Thought should be given to the retention of providers, as they are at high-risk for burn-out during this time.

The long term plan should include: (1) an analysis of policies that facilitate care provision during crises; (2) strategies to attract and retain more people, with an emphasis on people from diverse communities of identity and geography, to the field of behavioral health; (3) strategies to assess the most vulnerable populations for behavioral health concerns; (4) requirements for emergency plans for all behavioral health care services so that organizations and providers are prepared to immediately and effectively adapt their services during future crises.

Analyze state and local policy and advocate for changes that facilitate access to care during crises:

Participants, particularly behavioral health care service providers, discussed some policy adaptations made during the pandemic to facilitate service delivery that have been extremely helpful. They recommended continuation of such policies. Examples include having more flexible eligibility criteria to receive services, the use of verbal consent for telehealth services, and the cancellation of the limit on the number of BHS- funded sessions.

Providers also discussed the need to advocate for changes to Medi-Cal policies, including coverage for intensive outpatient or partial hospitalization programs for children and for

allowing for coordinated delivery and billing for drug treatment and mental health services from one organization.

Strategies to attract and retain a diverse body of behavioral health care service providers:

> ***"Ultimately, we need to invest in getting people of color into graduate programs – and paying for this – so they become behavioral health and health care providers."***
>
> **– Interview Participant**

Providers expressed concern about future shortages of providers and the need to have a robust workforce during times of crisis. Community members discussed extensively the need for more representation within the profession. Long-term planning, should therefore, the community said, include strategies to attract more young people to the field of behavioral health. Ideas included teaching young people about behavioral health professions, working with universities and foundations to create scholarship opportunities for graduate programs in behavioral health fields for people of color, and thinking about other incentives to recruit people to the field.

Strategies to assess the most vulnerable populations during crises:

Participants discussed that due to the necessary isolation from the pandemic, many people became "hidden victims" of household dysfunction and violence. Systems of outreach for these, and other vulnerable populations, need to be created, community members said. These systems will need to include cross-agency and cross-organization collaboration and information sharing. It was suggested that programs for seniors, including those offered by Aging and Independent Services, have built effective means of needs monitoring that might serve as models for other segments of the population.

Emergency contingency plans for all behavioral health care systems, organizations, and providers:

Many organizations have emergency plans in place to continue operations in times of emergencies. Participants expressed that all behavioral health care systems, organizations, and providers should be required to have such plans in place and that these plans now include provisions for continued operations when in-person contact is not possible.

Conclusions/Themes

The IPH and BHS are grateful to the community for their active participation in the behavioral health engagement process this year. Participants offered candid feedback about how the tragedies of the past months have impacted behavioral health and innovative, and provided creative ideas for how to keep the San Diego community healthy and thriving. An analysis of the feedback revealed four overarching, high-level themes to this year's community input: (1) Prepare; (2) Integrate and Coordinate; (3) Build Trust; and (4) Combat Stigma and Shame.

> ***"The pandemic has opened people's eyes about the importance of mental health. That might be the silver lining of the situation."***
>
> **– Family and Youth Community Listening Session Participant**

The following is a summary description of the themes as they emerged from participants discussion.

Prepare

The community was not prepared to meet the crises that arose in 2020. A continual theme throughout the engagement was that as individuals, organizations, and systems of care, preparation must become a priority. The community needs to better understand the short-term, mid-term, and long-term impacts of crises and create plans to address them – for the foreseeable future and for potential crises in the future. This preparation must include policy-level changes at the state and local levels, better training, and support for all essential workers, including behavioral health care workers, better systems of monitoring and needs assessment for the most vulnerable populations, a re-thinking of the spaces in which care is provided, and a focus on the long-term recruitment and retention of a diverse future behavioral health workforce.

Integrate and Coordinate

A need for a more holistic approach to care is crucial. Now more than ever, the separation of services for basic needs, physical health needs, and behavioral health needs makes ensuring the well-being of the community virtually impossible. Care centers – virtual or in person – where people can get multiple needs met are essential. Coordination with emergency departments is also important.

Build Trust

Community members are suffering, and current crises have deepened the mistrust many communities feel toward governmental agencies and community organizations. A focus on trust building within communities is a crucial prerequisite to serving those communities. Strategies to build trust include acknowledging, assessing, and openly discussing systemic

racism, utilizing peer mentor programs, hiring behavioral health care providers from within the community, allowing community members to participate in the design of behavioral health programs, creating work environments that lend to the retention of a diverse workforce and requiring anti-racist education and practices.

Combat Stigma and Shame

Building trust and combatting the stigma and shame often associated with behavioral health services are mutually dependent efforts. Stigma will be lessened by having providers who are trusted. Shame can be addressed by creating tailored, meaningful messaging for specific communities about behavioral health and having those messages delivered by trusted leaders. Non-traditional approaches to behavioral health care might appeal to people who are ashamed to receive traditional services, like therapy. And the implementation of behavioral health education into the regular curriculum at schools, in age-appropriate ways at each grade level, will help normalize discussions about behavioral health for future generations.

ANNUAL RESULTS COMPARISON

The goal for the annual BHS community engagement process is the same each year – to solicit in-depth feedback from community members to help inform programming. The focus of the engagements varies year-to-year so that all aspects of the system of care receive attention over time. Last year, for example, the theme of the engagement process was prevention and early Intervention (PEI), while earlier years centered around effective treatments and interventions.

This year, BHS recognized the urgent need to discuss how current crises, primarily the COVID-19 pandemic but also episodes of racial injustice, were impacting behavioral health. Along with that, BHS wanted to know what leadership should be thinking about moving forward to enhance individual resiliency and keep communities strong and thriving despite the ongoing tragedies since March of 2020. This was a different approach, and the community seemed to appreciate the opportunity to come together and share concerns and ideas, as reflected in their positive evaluations of the process.

An examination of the results from this year compared to the past three years reveals a new intensity to concerns about behavioral health. Community members strongly expressed that San Diego is experiencing a behavioral health care crisis. Other new findings include a focus on addressing racism, caring for behavioral health care providers, developing peer mentoring and other less traditional behavioral health care approaches, and re-evaluating the substance use disorder continuum of care. Despite these differences, several findings were like past years including concerns about rising levels of mental health issues, an interest in community-designed and delivered services and messaging, and a desire to prioritize behavioral health

education. Care coordination and cultural competency, along with building trust, were themes that recurred this year. The need to prepare for oncoming behavioral health crises and to prioritize combatting stigma and shame were new themes that emerged this year.

New Findings

San Diego is in a behavioral health crisis that it was unprepared to meet and that will worsen in the coming months.

The first notable difference in the community's input this year was the tone of the conversations. Unlike previous years, participants were more focused on urgent needs and conveyed a sense of intense community suffering, as illustrated by the frequent mentions of feeling overwhelmingly bereft, fearful, uncertain, and angry. Discussions about the community's behavioral health focused more on root causes and on generalities and less on specific mental health or substance use issues.

The primary finding of the engagement this year was that the community believes that San Diego County is experiencing a behavioral health crisis and that this crisis will worsen over the coming months until a return to more normal routines is allowed. Instead of discussing prevention, like last year, the community talked about preparation – both the lack of preparation to meet behavioral health needs during a pandemic and the need to create concrete short-term and long-term plans to meet those needs and to prepare for future crises. Community members had specific suggestions to incorporate into short-term and long-term planning.

Underlying the crisis is differential access to and effectiveness of education and care for various members of the population. The new reliance on telehealth and virtual education has brought disparities in access to care into sharp focus and has left high-risk people who are isolated without a safety net of people to assess their needs. In addition, the community emphasized that until basic needs are met, behavioral health cannot be a priority, and because so many people are struggling to survive, they are unable to take care of their behavioral health needs. All this combined with the decrease in utilization of behavioral health services has created an epidemic of its own – growing and unmet behavioral health needs. Concerns about access, social determinants of health, and utilization of services were discussed at community engagements in previous years. The nature of these concerns has, however, changed, and the concerns have grown significantly more serious.

Racism must be acknowledged and addressed.

The other factor that has contributed to worsening behavioral health is a sense of growing, overt racism, including violent racist acts, against people of color, the community emphasized. And while cultural competency and equity have been important topics for the past two

community engagements, this year the discussions shifted to a need to have more direct acknowledgement of how racism has helped create the disparities and injustices that have contributed to the behavioral health crisis. The community outlined specific communities that have suffered disproportionately during the tragedies of the past year and emphasized that comprehensive assessment of racism within systems, along with the implementation of anti-racist practices are necessary components of improving behavioral health programming and services. The representation of marginalized groups, including BIPOC and immigrants, in the behavioral health care services workforce was frequently cited as one necessary component to combat racism.

Behavioral health care providers need support and training.

A key finding at this year's engagement that has not been extensively discussed in past years is the impact of COVID-19 on essential workers, particularly behavioral health care providers. Behavioral health care providers had to change to what was, for most, an entirely new way of providing care during a time of extreme stress for their clients – and for them. The community was adamant that, to retain care providers, care must be provided for them. In addition, providers want professional development to learn best practices for the provision of telehealth care and to talk about pressing current issues like racism and the pandemic.

Peer mentoring and other less traditional approaches to behavioral health care are critical to address the behavioral health crisis.

While the community agreed, like past years, that there is inadequate access to affordable, timely, relevant behavioral health care overall, this year, they placed more emphasis on the idea that less traditional approaches to care need to be incorporated into the continuum of care. Peer mentoring was suggested to increase behavioral health support at nearly every engagement; it was described as a tool to expand access, build trust, and lessen stigma. Non-verbal therapies and other activities not traditionally thought of as therapeutic, like nature walks and community conversations, were discussed as vitally important approaches during times of extreme trauma.

The substance use disorder continuum of care should be re-evaluated.

In past years, conversations about substance use centered primarily on specific substances of concern, including vaping, marijuana, fentanyl, and opioids. And while these substances were mentioned this year, the community was more concerned about increased substance use problems, including usage, relapses, and overdoses and about the gaps in immediate access to high quality substance use treatment. People in recovery and treatment providers emphasized that telehealth options have generally not been well-received by those with substance use issues and, therefore, more people are without care, causing relapses and overdoses. People

who seek care are turned away from emergency departments but cannot easily access beds in detoxification facilities.

Findings Similar to Past Years

More people are experiencing anxiety and depression.

Like the findings of last year's engagement, the community identified increasing rates of anxiety and depression as an important concern, and they noted with alarm that many people are experiencing these conditions for the first time due to the events occurring this year. Others, they said, are experiencing more acute or severe symptoms. Interestingly, two of the same root causes of this deterioration were described both last year before the pandemic, and this year: growing isolation and heavier reliance on social media and technology. The need for social distancing during the COVID-19 pandemic has contributed to even greater isolation, a problem cited as critical before the pandemic began.

Behavioral health services and messaging should be developed in and for the communities they serve.

For each of the last four years, the delivery of services within communities was cited as a specific strategy necessary to improving behavioral health. This year, feedback include the need to involve communities in the design and delivery of services with a particular emphasis on hiring people from within the community to provide the services. In addition, participants stressed that messaging about behavioral health issues must be created by people within the communities, must be delivered in modes meaningful to that community, and must be delivered by trusted members of those communities. Youth were emphatic that they want and need to hear from other youth.

Education about behavioral health must be implemented in schools.

A finding common to the last two years was the necessity of incorporating behavioral health education into the K-12 curriculum. Students, teachers, and other school personnel want and need to understand the signs and symptoms of behavioral health issues, would like conversations about behavioral health to become normalized from a young age, and need tools to help them when they are concerned about others. If developmentally behavioral health education were a regular part of the school curriculum, the community said, stigma would be greatly reduced and the public's ability to help people who are struggling would be enhanced.

Comparison of Themes and Conclusions

Recurring Themes

Care Coordination

Every year since 2016, care coordination has been an overarching theme named by the community as a priority. Last year, for example, the community extensively discussed the necessity of integrating substance use and mental health care. For the past four years, the community has been emphatic that to truly improve behavioral health, social determinants of health, such as poverty, unemployment, and homelessness must be simultaneously addressed. This year, however, the tone of these conversations changed. Community members expressed desperation over their own situations and that of their clients. Massive job loss, poverty, and food insecurity have occurred because of the COVID-19 pandemic while behavioral health service usage has declined. The community is frustrated that resources are siloed and emphasized that until people's basic needs are met, there is little point in offering them behavioral health services.

Cultural Competency and Building Trust

For the past four years, the community has prioritized the provision of culturally competent services to improve the behavioral health of the community. The community is clear that when service providers are from different backgrounds and speak different languages than clients, barriers are created. Each year, community members repeatedly emphasized that they want and need services to be offered in their neighborhoods by members of the group with whom they identify. Specifically, they have asked that the County make intentional hires from specific groups to serve those groups.

This year, the community expressed a desire to go further than ensuring cultural competency. They want the County to assess its own racism, to implement anti-racist practices, to demand anti-racist practices from their contractors and to be transparent and direct about the findings of their assessment. They discussed how the mistrust of the government has grown, as has the mistrust of behavioral health service providers. This trust will only be rebuilt, they said, with acknowledgement of the current and historic systemic racism which has contributed to the current behavioral health crisis.

Trust is also built when BHS leaders partner with religious and other community members to disseminate information and messaging in a way that is meaningful to the targeted audience, according to participants. In addition, trust is created when they see BHS leaders at community events, when BHS commits to ensuring that all needs are met (not just behavioral health needs), and when the leadership has representation from diverse communities.

Emerging Themes

Preparation

In contrast to previous years, this year an overarching theme was preparation. The community was emphatic that San Diego was unprepared to meet the behavioral health needs of people during a pandemic. They also emphasized that behavioral health needs will grow in the coming months. As such, they believe a plan should be made to meet these needs in the short-term and to prepare for future crises.

Combatting Stigma and Shame

Raising awareness and overcoming stigma were discussed in 2016, 2018, and 2019, with two specific suggestions: (1) conducting a public awareness campaign; and (2) increasing education efforts about behavioral health for children, young adults, families, school personnel, and community members.

This year, while those suggestions were made again, the conversations were broader and emphasized the deep shame that many people feel about their struggles with mental health and substance use issues. Many communities of identity and geography, including immigrants from many different areas, LatinX, Black, and Asian/Pacific Islander individuals, and those living in rural areas emphasized that people in their community simply will not seek help for behavioral health problems even when they are in dire need. They discussed the strength and resiliency of people who have faced discrimination and racism for years, the dearly held values of self-reliance, hard work, and discipline, and the belief that seeking help is in direct conflict with those values. Conversations within those communities about how to overcome these strong, deeply held feelings are necessary, but these conversations need to occur within and by people in those communities. This theme ties in with the theme of building trust – to combat stigma and shame, a necessary first step is to build trust in these communities starting with representative hiring and partnerships with community leaders.

PARTICIPANT EVALUATION AND IPH RECOMMENDATIONS

Participant Evaluations

Participants were asked to complete a survey assessing their satisfaction with listening sessions and focus groups. Results are summarized below. The survey link was distributed to all participants 15 minutes prior to the end of each event and via two additional emails sent three days apart. The response rate on the survey was 58% (n=112).

Overall Satisfaction

Event participants were asked to rate their overall satisfaction with the Community Listening Sessions or Focus Group discussions. Overall satisfaction was high with 92% of participants reporting being *satisfied* or *very satisfied* (Table 16).

Table 16. Overall Satisfaction with the Event

Event		Percent within each category[1]			
	n	*Not at all Satisfied*	*Somewhat Satisfied*	*Satisfied*	*Very Satisfied*
BHS Provider Listening Session	58	0%	10%	53%	36%
Youth and Family Listening Session	30	0%	7%	27%	67%
Trauma Informed Guide Team Focus Group	5	0%	0%	0%	100%
LatinX Focus Groups	6	0%	0%	17%	83%
Individuals receiving care for SMI Focus Group	3	0%	0%	33%	67%
Loved ones of individuals receiving care for SUD Focus Group	5	0%	0%	20%	80%
Rural Community Focus Group	5	0%	0%	20%	80%
Total	**112**	**0%**	**7%**	**38%**	**54%**

[1]Totals may not sum to 100% due to rounding.

Event Format

Participants were asked about the convenience of the event format. 100% of participants rated it as *convenient* or *very convenient*.

Table 17. How convenient was the use of a virtual platform for this meeting?

Event	*n*	Percent within each category[1]			
		Not at all Convenient	***Somewhat Convenient***	***Convenient***	***Very Convenient***

BHS Provider Listening Session	56	0%	2%	25%	73%
Youth and Family Listening Session	30	0%	0%	37%	63%
Trauma Informed Guide Team Focus Group	5	0%	0%	0%	100%
LatinX Focus Groups	6	0%	0%	17%	83%
Individuals receiving care for SMI Focus Group	3	0%	0%	33%	67%
Loved ones of individuals receiving care for SUD Focus Group	5	0%	0%	0%	100%
Rural Community Focus Group	5	0%	0%	0%	100%
Total	**110**	**0%**	**1%**	**25%**	**75%**

[1]Totals may not sum to 100% due to rounding.

Day and Time of the Event

Overall, participants found that the selected days of the week suited their schedules with 83% reporting that they *agreed* that the day of the week of the event was a good fit for their schedules.

Table 18. Day of the week was a good fit for schedule

Event	n	Percent within each category[1]			
		Disagree	*Somewhat disagree*	*Somewhat agree*	*Agree*
BHS Provider Listening Session	56	2%	0%	14%	84%
Youth and Family Listening Session	30	0%	0%	23%	77%
Trauma Informed Guide Team Focus Group	5	0%	0%	0%	100%
LatinX Focus Groups	6	0%	0%	50%	50%

Individuals receiving care for SMI Focus Group	3	0%	0%	0%	100%
Loved ones of individuals receiving care for SUD Focus Group	5	0%	0%	0%	100%
Rural Community Focus Group	5	0%	0%	0%	100%
Total	**110**	**1%**	**0%**	**16%**	**83%**

[1]Totals may not sum to 100% due to rounding.

Participants were also asked about whether the time of the event was a good fit for their schedules. 86% of participants *agreed* all times of day were convenient.

Table 19. Time of event was a good fit for schedule

Event	*n*	Percent within each category[1]			
		Disagree	*Somewhat disagree*	*Somewhat agree*	*Agree*
BHS Provider Listening Session	58	3%	2%	7%	88%
Youth and Family Listening Session	30	0%	0%	20%	80%
Trauma Informed Guide Team Focus Group	5	0%	0%	20%	80%
LatinX Focus Groups	6	0%	0%	33%	67%
Individuals receiving care for SMI ocus Group	3	0%	0%	0%	100%
Loved ones of individuals receiving care for SUD Focus Group	5	0%	0%	0%	100%
Rural Community Focus Group	5	0%	0%	0%	100%
Total	**112**	**2%**	**1%**	**12%**	**86%**

[1]Totals may not sum to 100% due to rounding.

Topics

Participants were asked whether the topics covered at the event were useful. 100% of participants in the Community Listening Sessions *agreed* or *somewhat agreed* that the topics were useful and 100% of Focus Group participants *agreed* the topics were useful.

Table 20. Topics covered at the event that were useful.

Event	n	Percent within each category[1]			
		Disagree	*Somewhat disagree*	*Somewhat agree*	*Agree*
BHS Provider Listening Session	58	0%	0%	22%	78%
Youth and Family Listening Session	30	0%	0%	10%	90%
Trauma Informed Guide Team Focus Group	5	0%	0%	0%	100%
LatinX Focus Groups	6	0%	0%	0%	100%
Individuals receiving care for SMI Focus Group	3	0%	0%	0%	100%
Loved ones of individuals receiving care for SUD Focus Group	5	0%	0%	0%	100%
Rural Community Focus Group	5	0%	0%	0%	100%
Total	**112**	**0%**	**0%**	**14%**	**86%**

[1]Totals may not sum to 100% due to rounding.

How Participants Heard About Events

Lastly, attendees were asked how they learned of the events. As in past years, email communication appeared to be the most effective mode of recruitment.

Table 21. How attendee learned of event

Event	n	Percent of Respondents[1]					
		Flyer	*Friend/Colleague /Family Member*	*Email*	*Newspaper*	*Social Media*	*Other*
BHS Provider Listening Session	57	9%	33%	58%	0%	7%	9%

Youth and Family Listening Session	30	10%	33%	30%	7%	27%	10%
Trauma Informed Guide Team Focus Group	5	0%	60%	60%	0%	0%	0%
LatinX Focus Groups	6	0%	50%	50%	0%	0%	0%
Individuals receiving care for SMI Focus Group	3	67%	0%	0%	0%	33%	67%
Loved ones of individuals receiving care for SUD Focus Group	5	20%	20%	40%	0%	20%	20%
Rural Community Focus Group	5	0%	60%	20%	0%	20%	0%
Total	**111**	**10%**	**35%**	**46%**	**2%**	**14%**	**10%**

[1]Percentages and totals are based on respondents.

Suggestions, Praise, and Other Comments

The last two questions were open-ended and asked participants for suggestions for improvement and other comments. These responses were grouped into categories and are presented below.

Suggestions for improving events/listening sessions.

Outreach

- Engage the FQHCs (Federally Qualified Health Centers). Seek out the grassroots organizations which are the closest to targeted communities.
- Publicize better so that more people and school staff are aware of these events. This year, it was only mentioned in a single message on one platform, not even on the school or ASB's Instagram which is the most efficient way to spread the word.
- Market these great sessions a bit more to reach the families and residents that are struggling the most.
- Perhaps outreach through libraries (may be more useful in non-COVID-19 times), and youth focused work with schools/school counselors so students can get credit for attending.

Engagement

- Include focus groups for Native American communities as well as Deaf/Hard of Hearing communities.
- Need to hear from more youth, parents, and educators.
- Include more faith-based providers/pastors/etc. which are often the first-place people go for support as well as law enforcement (PERT).
- Very disappointed that there were not more "community" and other stakeholder participation over provider attendance. This session did not feel like gathering a broad opinion as to what the community sees happening now in our County or feels what needs to be added.
- Organize more of these events so different stakeholders can team up together: prevention, treatment, post-treatment.

Scheduling Events

- Increase participation by getting on the agenda of existing virtual sessions of different groups and organizations.
- To ensure more participation, schedule events on weekdays: later afternoon and early evenings.
- Have events scheduled in the late afternoon, early evening.
- When scheduling events, check school calendars for convenient day and time. The schedule this year was not convenient as schools were approaching finals when semester grades are submitted.

Pre-event Planning

- Possibly a pre-survey to see common themes or needs prior to meeting.
- Mention the agenda/discussion topics and the length of the session in the email so that participants can plan their schedule accordingly.
- Invite the Q and A "pods" to meet as a group with the planners.
- Provide an agenda before the event starts.

Discussion Topics

- Ask about barriers/challenges to accessing services.
- Everyone pretty much knows the negative impacts of alcohol and drugs, we need to come up with solutions and ideas of how we can provide more resources, etc. to those in need.
- Allow space for open-ended topics and areas of concerns beyond the questions that facilitators ask. Example of topics that can be incorporated are: ‘Challenges that organizations are facing with their entire relationship with BHS’.
- Further specify questions for youth.

- Provide some examples about discussions topics to help participants build from.
- Include 'medical case management' in the agenda. Ensure funds for people to reach out to connect and find out if people are getting their medical needs met during pandemic.

Facilitation Suggestions

- Incorporate more structured conversation so that all participants can contribute adequately instead of those who dominate the group.
- Add more group discussion before break-out groups.
- Include an ice-breaking session (game, etc.) that can help attendees to be at ease, so more people are comfortable participating.
- Consider ways to coordinate reporting of topics/themes from different breakout groups (e.g., check box). In that way, if a topic was already discussed then only new content will be added and repetition can be avoided.
- For large sessions, many of the same issues were stated in the presentation of the breakout "reporters". A solution for effective group categorization may be dividing the SUD and MH providers - or a third large category which would be both.

Session Timing

- Mention the number and content of questions ahead of time so participants can organize thoughts.
- Allocate increased proportion of time for discussion of problem-solving by decreasing time for sharing.
- Presentations from small groups had a large amount of overlap. A better use of that time may have been discussing additional questions in breakout groups.
- Improve time allocation for each topic during breakout sessions and anticipate required time needed to accomplish goals.
- Shorten the breakout sessions and allocate more time for reporting. Limit the whole Listening Session to 90 minutes.
- Specify time limit and communicate in advance, ideally in the breakout sessions so reporters can tailor their remarks. Manage the report outs better so each group get similar time.
- Keep session to 2 hours or less to keep people engaged.

Technology-Specific Issues/Suggestions

- Enable chatting among participants so that attendees can connect with each other if they want to.
- Allow attendees to save the chat for future reference and to share with colleagues.

- Organize and utilize the breakout room function more effectively so that participants are added to relevant breakout rooms where they can truly contribute to the conversation.
- It was inconvenient that the link was not sent out until after business hours the day before the event.
- It would be helpful to use a whiteboard for taking notes in breakout rooms.
- Offer a way to share thoughts in writing (e.g., Google Form). Typing in the chat quickly before the subject of the conversation changed was at times challenging.
- Apart from some technical difficulties at the beginning, the overall session went well.
- Use polls during Zoom sessions.
- Provide Zoom ID and passcode at an earlier time next time. It arrived almost within hours of the event.

Positive Feedback

- A great virtual format, accessible and timely.
- These community listening sessions are very useful and productive, not much improvement needed because it is already great.
- Very organized and easy to follow through.
- Good responses from participants
- Liked the forum. More time in the breakout group can be more useful but overall a great session.
- The way it was handled was great! The only change I would do is to specify questions for youth a little more.
- Loved the voice of youth being included and embraced.
- Group was right size, facilitators did a good job.
- Enjoyed the discussion and found it helpful to be able to contribute thoughts and ideas.
- Happy to see two of our strong providers participating in the group SD-TIGT appreciates tremendously the opportunity to engage with you on these imperative public health crisis realities and healing-centered, equity-focused solutions for families we serve, across the lifespan, and on behalf of cross-sector colleagues throughout our region.
- Thank you for hearing my voice and the opportunity to provide feedback.
- Thank you so much for doing a rural focused listening session! All too often rural voices are not heard, and it was so wonderful to witness their voices, their insights and their challenges being heard and included in this.
- Appreciate the meetings that are being had to help and nurture students and adults during this difficult time. These opportunities to share information and hear from others, especially youth attendees, were valuable for youth providers.

- It was helpful to have such a varying group of participants from different programs/specialties.
- The facilitator/s did a very good job. They listened, summarized the comments, were respectful and encouraging. I may have liked this one even better than the previous years that were in person. Thanks!
- Loved this opportunity as a first-time participant.
- It was good having the discussion questions ahead of time.
- The flow was nice, and the encouragement of participation enhanced the experience.

Other comments

- It would be helpful to bring in some of the activities the county is already putting in place to address these issues.
- More talk about coping and how to leave abusive relationships (any kind) during the pandemic.
- Want to know of ways to begin a collaboration on the education of/on mental health. To begin a "Koalaty Kare" campaign to generate awareness of the prevalence and hope for recovery from mental health disorders, people with whom connection can be made for any future partnerships.
- A tie in between Luke's comments about equity and the prompt questions
- Create a non-law enforcement (no handcuffs) Clinician team that can respond to BH issues/situations to de-escalate and connect to treatment.

IPH Recommendations for Future Community Engagement Processes

Results from the satisfaction surveys show that the community was satisfied with this year's engagement process. Based on their feedback and an analysis of feedback from the previous two years, the IPH recommends several modifications to improve future engagements.

Change to a system of ongoing, rather than discrete, engagement that allows for more time to plan, build relationships, and implement the events

A key theme that emerged from this year's engagement was that the community wants and needs time to build trust with BHS. An ongoing engagement process would allow for more time to cultivate and sustain trusting relationships with community leaders and enhance community participation. With additional time to plan, the community could also have a more active voice in the planning of the process, the time for recruitment could be expanded, and the number of people who attend events would almost certainly increase.

This year, the time to plan and execute events was extremely compressed with only four months to plan, recruit for, and execute all engagement events. Unfortunately, because of the

time constraints, the events took place during the holiday season (November – December) and, more importantly, during a deadly surge of COVID-19. An ongoing process would allow for flexibility in scheduling and for contingency planning in the case of crises, like the current pandemic.

An extended process would also allow for more comprehensive recruitment and specific outreach to under-represented groups. The IPH was able to reach out to, and conduct interviews with, individuals from groups who were not well-represented at the events. This could not be done, however, until attendance data could be analyzed so that these groups could be identified. At that point, too little time was left to do as much outreach as would be ideal to ensure that all groups were able to contribute.

Host More Focus Groups and Utilize Best Practices for Recruitment

Focus groups are an ideal way to hear the voices of specific and targeted community members. This format seeks quality feedback over quantity, providing rich and relevant data. Best practice for recruiting for focus groups, however, includes purposeful sampling, rather than mass recruitment. Attempts to ensure representation through a process of nearly random sampling from the community are ineffective, as evidenced by the low rates of attendance at this year's focus groups. Purposeful sampling can include joining existing meetings (as done in previous BHS engagements such as the focus group with peer support workers at Recovery International in 2018) or to ask leaders in a particular community to pull together a group for the engagement (such as the focus group with foster youth in 2019/2020). In this way, a level of trust already exists among the people participating either through shared membership in a group or shared trust in a community leader. This existing trust creates an environment that facilitates open and honest conversation. This practice also ensures good attendance numbers at the groups. As discussed above, a more robust period of planning would enhance BHS's ability to host multiple focus groups and gather the feedback of diverse populations across the county.

Consider Offering a Variety of Engagement Structures

This year, due to the COVID-19 pandemic, all engagement events were held virtually, whereas in previous years, all events were held in person. There are conveniences and benefits to both event structures. The IPH recommends that, when it is again safe to do so, that some events continue to occur virtually, while others occur in-person, giving the community multiple choices for how to engage. Additionally, last year, due to an event site error, a planned, indoor structured event had to be held more informally outdoors. The people who participated in that event gave it overwhelmingly positive feedback. Consideration should be given, therefore, to hosting both structured, formal events and less structured, more casual events.

Share the report with past participants and create systems of ongoing feedback and follow-up.

Several attendees at the events expressed frustration about feeling that nothing happens with the feedback they give. Most had not seen the previous year's report and did not know where to find it. It is important to inform the community about how their input is utilized and to offer them the opportunity to easily access and read the reports from prior engagement efforts. Detailing specific ways in which their ideas have been incorporated into BHS programming would be especially helpful in reducing frustration and building trust. BHS should communicate regularly with the participants at the engagements to allow for ongoing conversation and follow-up about behavioral health in San Diego County.

Appendix

County of San Diego
Health and Human Services Agency
Behavioral Health Services
Community Engagement Report
Fiscal Year 2020-21



SAN DIEGO STATE UNIVERSITY

Institute for Public Health

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Appendix 1: Focus Group Questions

SAN DIEGO STATE UNIVERSITY
Institute for Public Health

Behavioral Health Services Community Engagement 2020-21
Guide for Focus Groups: Questions and Structure

Each focus group will have at least three IPH staff in attendance with roles as follows:

- Primary facilitator
- Monitor for chat box/technology issues
- Note taker

Focus groups will begin with introductions, instructions about how to use Zoom and proper Zoom etiquette, and an overview of questions to be discussed.

While each focus group will discuss similar questions, ***questions will be tailored*** to make sense for that group.

Facilitators will share with attendees that they were invited to participate in an in-depth conversation about impacts to mental health and substance use from current events, including COVID-19 and other community conditions. We want to provide this opportunity to share what behavioral health concerns have arisen in recent months.

Focus Group with the Black/African American Community

Question 1: What are the most serious ***mental health*** concerns for you and people you know right now?

Prompts:

- Have these changed in recent months?
- Has the pandemic affected the mental health of people in your community?
- If so, how?
- If so, has your ability to get care for yourself or loved ones changed in any way as a result of recent crises?
- How have the recent incidents of social injustice affected your mental health or the mental health of people you know? If so, how?

Question 2: What are the most serious ***substance use issues*** for you or people you know right now?

Prompts:

- Have these changed in recent months?
- Has the pandemic affected substance use issues for people in the community?
- If so, how?
- If so, has your ability to get substance use treatment for yourself or loved ones been impacted?
- How have the recent incidents social injustice affected substance use issues for people in your community? How?

Question 3: What kinds of mental health and/or substance use treatment services do you need to make sure you, your family, and the community come out of the recent crises stronger than ever?

Prompts:

- What services and programs have been helpful to you or people you know over the past several months?
- What community concerns should the County think about when developing programs?
- What kinds of services should BHS be making available?
- What types of treatment services are needed?
- What types of preventive services are needed?
- What kind of public messaging is needed?

Focus Groups with the LatinX community

Question 1: What are the most serious ***mental health*** concerns for you or people you know right now?

Prompts:

- Have these changed in recent months?
- Has the pandemic affected the mental health of people in the community?
- If so, how?
- If so, has your ability to get care for yourself or loved ones been impacted?
- How have the recent incidents of social injustice affected the mental health of people in your community?

Question 2: What are the most serious ***substance use issues*** in the community right now?

Prompts:

- Have these changed in recent months?
- Has the pandemic affected substance use issues for people in the community?
- If so, how?
- If so, has your ability to get substance use treatment for yourself or loved ones been impacted?
- How have the recent incidents of social injustice affected substance use issues for people in the community?

Question 3: What kinds of mental health and/or substance use disorder services are needed to make sure you, your family, and the community come out of the recent crises stronger than ever?

Prompts:

- What services and programs have been helpful to you or people you know over the past several months?
- What community needs should the County be thinking about when developing programs?
- What kinds of services should BHS be making available?
- What types of treatment services are needed?
- What types of preventive services are needed?
- What kind of public messaging is needed?

Focus Group with Essential Workers (Behavioral Health Services Providers)

Question 1: What are the most serious ***mental health*** concerns facing essential workers, like you, right now?

Prompts:

- Have these changed in recent months?
- Has the pandemic affected the mental health of essential workers?
- If so, how?
- Has the pandemic affected the mental health of your families?
- Has your ability (or that of other essential workers) to get care for yourself or loved ones been impacted?
- How have the recent incidents of social injustice affected the mental health of essential workers?

Question 2: What are the most serious ***substance use issues*** you are seeing with essential workers right now?

Prompts:

- Have these changed in recent months?
- Has the pandemic affected substance use issues for essential workers? If so, how?
- Has it been harder for essential workers to get substance use services?
- How have the recent incidents of social injustice affected substance use issues for essential workers?

Question 3: What kinds of mental health and/or substance use treatment services are needed to make sure you, your family, and the community come out of the recent crises stronger than ever?

Prompts:

- What services and programs have been helpful to essential workers over the past several months?
- What kinds of services should BHS be making available?
- What types of treatment services are needed?
- What types of preventive services are needed?
- What kind of public messaging is needed?

Focus Group with Asian/Pacific Islander community

Question 1: What are the most serious ***mental health*** concerns for you and people you know right now?

Prompts:

- Have these changed in recent months?
- Has the pandemic affected the mental health of people in your community?
- If so, how?
- If so, has your ability to get care for yourself or loved ones been impacted?
- How have the recent incidents of social injustice affected the mental health of people in the community?

Question 2: What are the most serious ***substance use issues*** in the community right now?

Prompts:

- Have these changed in recent months?
- Has the pandemic affected substance use issues for people in your community?
- If so, how?
- If so, has your ability to get substance use treatment for yourself or loved ones been impacted?
- How have the recent incidents of social injustice affected substance use issues for people in the community?

Question 3: What kinds of mental health and/or substance use treatment services are needed to make sure you, your family, and the community come out of the recent crises stronger than ever?

Prompts:

- What services and programs have been helpful to you or people you know over the past several months?
- What community needs should the County think about when developing programs?
- What kinds of services should BHS be making available?
- What types of treatment services are needed?
- What types of preventive services are needed?
- What kind of public messaging is needed?

<u>Focus Group with family members of people receiving services for severe mental illness (SMI)</u>

Question 1: How has the pandemic affected the ***mental health*** of your loved one or other people you know?

Prompts:

- Has your ability to get care for your loved ones been impacted?
- How have the recent incidents of social injustice affected your loved one's mental health?

Question 2: How has the pandemic affected your own well-being?

Prompts:

- Has your ability to get care for yourself been impacted?
- How have the recent incidents of social injustice affected your well-being?

Question 3: What kinds of mental health and substance use treatment services are needed to make sure that people who struggle with serious mental illness come out of the recent crises stronger than ever?

Prompts:

- What services and programs have been helpful over the past several months?
- What would be helpful to you to ensure that you are ok as a loved one of someone may have a serious mental illness?
- What community concerns should the County think about when developing program services?

- What kinds of services should BHS be making available?
- What types of treatment services are needed?
- What types of preventive services are needed?
- What kind of public messaging is needed?

Focus group with people receiving services for a severe mental illness (SMI)

Question 1: How do you think the pandemic has affected the well-being of people who have a mental illness?

Prompts:

- Has your ability to get good care been impacted? How?
- How have the recent incidents of social injustice affected your mental health or the mental health of people you know?

Question 2: What kinds of mental health and/or substance use services do people with mental illness need to make sure they come out of the recent crises stronger than ever?

Prompts:

- What services and programs have been helpful over the past several months?
- What community needs should the County think about when developing program service?
- What kinds of services should BHS be making available?
- What types of treatment services are needed?
- What types of preventive services are needed?
- What kind of public messaging is needed?

Focus group with people receiving services for a substance use disorder

Question 1: How do you think the pandemic has affected people who are struggling with substance use issues?

Prompts:

- Has the pandemic made it harder to get treatment for substance use issues?
- How have the recent incidents of social injustice impacted those who are struggling with substance use issues?

Question 2: What kinds of mental health or substance use treatment services do people who are struggling with substance use issues need to make sure they come out of the recent crises stronger than ever?

Prompts:

- What services and programs have been helpful over the past several months?
- What community needs should the County think about when developing program services?
- What kinds of services should BHS be making available?
- What types of treatment services are needed?
- What types of preventive services are needed?
- What kind of public messaging is needed?

Focus group with family members of people receiving services for a substance use disorder

Question 1: How do you think the pandemic has affected people who are struggling with substance use issues?

Prompts:

- Has the pandemic made it harder to get treatment for substance use issues?
- How have the recent incidents of social injustice impacted those who are struggling with substance use issues? If so, how?

Question 2: As someone who loves someone with a substance use issue, how has the pandemic affected your well-being?

Prompts:

- Has your ability to get care for yourself been impacted?
- How have the recent incidents social injustice affected your well-being? If so, how?

Question 3: What kind of mental health and substance use treatment services do people who are struggling with substance use issues need to make sure they come out of the recent crises stronger than ever?

Prompts:

- What services and programs have been helpful over the past several months?
- What community needs should BHS think about when developing program services?
- What kinds of services should BHS be making available?
- What would be helpful to you as the loved one of someone with a substance use issue?
- What types of treatment services are needed?
- What types of preventive services are needed?
- What kind of public messaging is needed?

Focus Group with the Trauma-Informed Guide Team

Question 1: What are the most serious ***mental health*** concerns you are seeing in the people you work with right now?

Prompts:

- Have these changed in recent months?
- Has the pandemic affected the mental health of people you serve?
- If so, how?
- Has access to mental health care been impacted for the people you serve?
- How have the recent incidents of social injustice affected the mental health of people the people you serve?

Question 2: What are the most serious ***substance use issues*** you are seeing in the people you work with right now?

Prompts:

- Have these changed in recent months?
- Has the pandemic affected substance use issues for the people you serve?

- If so, how?
- Has access to substance use treatment services been impacted for the people you serve?
- How have the recent incidents social injustice affected substance use issues for the people you serve?

Question 3: What does your community need from San Diego County BHS to address these issues?

Prompts:

- What services and programs have been helpful to the people you serve over the past several months?
- What community concerns should BHS be thinking about when developing program services?
- What kinds of services should BHS be making available?

Appendix 2: ListenToSanDiego.org Screenshots



HHSA LIVE WELL

The County of San Diego Behavioral Health Services
Virtual Community Listening Sessions

Each year, the County of San Diego Behavioral Health Services (BHS) collects community feedback about the behavioral health of San Diegans through a variety of activities including listening sessions, focus groups, and interviews. Feedback is used to inform program planning, and results are published annually in the MHSA Three-Year Program and Expenditure Plan and Annual Updates.

Register »

Tuesday, December 1, 2020

10 am - 11:30 am

This Community Listening session is **for people who provide mental health and/or substance use services in San Diego County.**

Saturday, December 12, 2020

11 am - 12:30 pm

This Community Listening session is open to **the public and focused on the impacts of COVID-19 on families and youth in our community.**

Youth 12-18 years old are invited to participate and may receive two hours of community service credits for attending

Servicios de Salud Conductual del Condado de San Diego
Sesiones de escucha comunitaria virtuales

Cada año, el departamento de Servicios de Salud Conductual del Condado de San Diego (County of San Diego Behavioral Health Services o BHS) recopila comentarios de la comunidad sobre la salud conductual de los habitantes de San Diego a través de una variedad de actividades que incluyen sesiones de escucha, grupos de enfoque y entrevistas. Los comentarios se utilizan para informar la planificación del programa, y los resultados se publican anualmente en el Programa de tres años, el Plan de gastos y las Actualizaciones anuales de la MHSA (Ley de Servicios de Salud Mental).

Regístrese »

Martes, 1 de diciembre de 2020

10 am - 11:30 am

Esta sesión de escucha comunitaria es para personas que brindan servicios de salud mental y / o consumo de sustancias en el Condado de San Diego.

Sábado, 12 de diciembre de 2020

11 am - 12:30 pm

Esta sesión de escucha comunitaria está abierta al público y se enfoca en los impactos de COVID-19 en las familias y los jóvenes de nuestra comunidad.

Los jóvenes de 12 a 18 años están invitados a participar y pueden recibir dos horas de créditos de servicio comunitario por asistir.

Vía Zoom

(El enlace de la reunión de Zoom se le enviará por correo electrónico después de inscribirse).



HHSA LIVE WELL

خدمات الصحة السلوكية لمقاطعة سان دييغو
جلسات الاستماع المجتمعية الافتراضية

تعليقات المجتمع حول الصحة السلوكية لسان دييغو من خلال مجموعة (BHS) كل عام، يجمع مكتب خدمات الصحة السلوكية لمقاطعة سان دييغو متنوعة من الأنشطة بما في ذلك جلسات الاستماع ومجموعات التركيز والمقابلات. تُستخدم التعليقات للمساعدة في وضع البرنامج على أساس مستنير. ويتم نشر النتائج سنويًا في البرنامج التابع لقانون الصحة العقلية ذي السنوات الثلاث وبرنامج الإنفاق والتحديثات السنوية.

سجل

الثلاثاء، 1 ديسمبر 2020	السبت، 12 ديسمبر 2020
صباحًا - 11:30 قبل الظهر 10	قبل الظهر - 12:30 ظهرًا 11

جلسة الاستماع المجتمعية هذه مخصصة للأشخاص الذين يقدمون خدمات الصحة العقلية و/أو تعاطي المواد المسببة للإدمان في مقاطعة سان دييغو.

جلسة الاستماع المجتمعية هذه متاحة للجمهور وتركز على آثار (COVID-19) كوفيد-19 على العائلات والشباب في مجتمعنا.

الشباب الذين تتراوح أعمارهم بين 12 و 18 عامًا مدعوون للمشاركة في الجلسة وقد يحصلون على نقاط تعادل ساعتين من خدمة المجتمع نظير حضورهم.

Zoom عبر برنامج

(عبر البريد الإلكتروني بعد التسجيل Zoom سيتم إرسال الرابط لاجتماع)



لا يمكنك الحضور؟

يمكنك طرح أفكارك واقتراحاتك أو طلب جلسة مقابلة فردية مع أحد أعضاء معهد الصحة العامة.

إرسال نموذج تقديم التعليقات/ طلب المقابلة

Ang Behavioral Health Services ng County ng San Diego
Mga Virtual na Sesyon ng Pakikinig sa Komunidad

Sa bawat taon, kinokolekta ng Behavioral Health Services (BHS, Mga Serbisyo sa Kalusugan ng Pag-iisip) ng County ng San Diego) ang feedback (saloobin) ng komunidad tungkol sa kalusugan ng pag-iisip ng mga tagoSan Diego sa pamamagitan ng iba't ibang aktibidad kabilang ang mga sesyon ng pakikinig, focus group, at panayam. Ginagamit ang feedback upang magbigay ng kaalaman sa pagpaplano ng programa, at inilalathala ang mga resulta taun-taon sa Tatlong-Taong Programa at Plano ng Paggasta at mga Taunang Update ng MHSA.

Magparehistro »

Martes, Disyembre 1, 2020

10 am – 11:30 am

Ang sesyon ng Pakikinig sa Komunidad na ito ay para sa mga taong nagkokaloob ng mga serbisyo sa kalusugan ng pag-iisip at/o paggamit ng alkohol o droga sa County ng San Diego.

Sabado, Disyembre 12, 2020

11 am – 12:30 pm

Ang sesyon ng Pakikinig sa Komunidad na ito ay bukas sa publiko at nakatuon sa mga epekto ng COVID-19 sa mga pamilya at kabataan sa ating komunidad.

Ang mga kabataang nasa edad na 12-18 taong gulang ang inilimbitahang makibahagi at maaaring makatanggap ng dalawang oras na kredit ng serbisyo sa komunidad para sa pagdalo.

SA PAMAMAGITAN NG Zoom

(Ipapadala sa iyo sa pamamagitan ng email ang link sa Zoom ng pagpupulong pagkatapos magparehistro)



Dịch vụ Sức khỏe Hành vi của Quận San Diego
Các buổi họp trực tuyến để tiếp nhận ý kiến cộng đồng

Hàng năm, Dịch vụ Sức khỏe Hành vi (Behavioral Health Services, hay BHS) của Quận San Diego thu thập ý kiến phản hồi từ cộng đồng về sức khỏe hành vi của cư dân San Diego thông qua một loạt các hoạt động, bao gồm các buổi tiếp nhận ý kiến, nhóm trọng tâm và những cuộc phỏng vấn. Thông tin từ các ý kiến phản hồi được sử dụng trong việc quy hoạch chương trình, và các kết quả được công bố hàng năm trong Chương trình Ba năm và Kế hoạch Chi tiêu cũng như các Bản Cập nhật Thông tin Hàng năm theo luật MHSA.

Đăng ký »

Thứ Ba, ngày 1 tháng 12 năm 2020

10 sáng - 11:30 sáng

Buổi Tiếp nhận Ý kiến Cộng đồng này dành cho những người cung cấp dịch vụ sức khỏe hành vi và/hoặc dịch vụ cho người sử dụng chất gây nghiện ở Quận San Diego.

Thứ Bảy, ngày 12 tháng 12 năm 2020

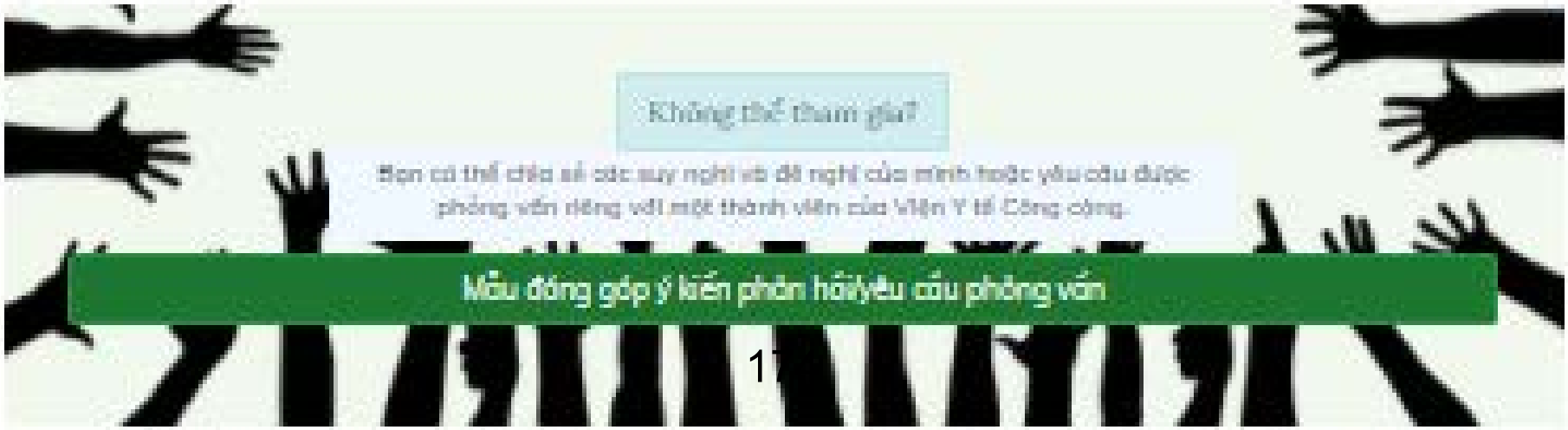
11 sáng - 12:30 trưa

Buổi Tiếp nhận Ý kiến Cộng đồng này dành cho toàn bộ cộng đồng và tập trung vào tác động của COVID-19 lên các gia đình và thanh thiếu niên trong cộng đồng chúng ta.

Thanh thiếu niên từ 12 đến 18 tuổi được mời tham gia và có thể nhận được tín chỉ phục vụ cộng đồng cho hai giờ tham gia.

Qua Zoom

(Bạn sẽ nhận được liên kết tham gia cuộc họp Zoom qua email sau khi ghi danh)



Không thể tham gia?

Bạn có thể chia sẻ các suy nghĩ và đề nghị của mình hoặc yêu cầu được phỏng vấn riêng với một thành viên của Viện Y tế Công cộng.

Mẫu đóng góp ý kiến phản hồi/yêu cầu phỏng vấn

Last Update: 11/18/2020

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خدمات بهداشت رفتاری کانتی سن دیگو
جلسات مجازی مباحثه اجتماعی

هر ساله، خدمات بهداشت رفتاری کانتی سن دیگو بازخورد اجتماعی درباره بهداشت رفتاری مردم سن دیگو را از طریق برگزاری فعالیتهای متنوعی، از جمله جلسات مباحثه، گروههای تمرکز و مصاحبه، جمع آوری می کند. این بازخورد به عنوان اطلاعات مورد نیاز برای طرح ریزی برنامه ها بکار برده می شود و نتایج آن نیز هر سال در برنامه سه ساله و طرح مخارج قانون خدمات بهداشت روان و به روزرسانی های سالانه منتشر می شود.

ثبت

سه شنبه، 1 دسامبر 2020

صبح 11:30 – 10

جاین جلسه مباحثه اجتماعی برای افرادی است که خدمات بهداشت روان و/یا مصرف مواد مخدر در کانتی سن دیگو ارائه می دهند.

شنبه، 12 دسامبر 2020

صبح 12:30 – 11

این جلسه مباحثه اجتماعی برای عموم آزاد است و بر روی اثرات کووید-19 بر خانواده ها و جوانان جامعه مان تمرکز می کند.

جوانان 12-18 سال برای شرکت در این جلسه دعوت می شوند و می توانند دو ساعت از واحدهای خدمات اجتماعی را برای شرکت در این جلسه دریافت نمایند.

از طریق Zoom

(پس از ثبت نام برای شما ایمیل می شود Zoom لینک جلسات)



نمی توانید شرکت کنید؟

شما می توانید افکار و پیشنهادات خود را به اشتراک بگذارید و یا برای یک جلسه مصاحبه فردی با یکی از اعضای مؤسسه سلامت عمومی درخواست دهید.

ارسال بازخورد/فرم درخواست مصاحبه

English

Feedback/Interview Request Form

You can share your thoughts and suggestions or request a one-on-one interview session with a member of the Institute for Public Health.

What would you like to do?

- [ ] Send Feedback
- [ ] Request an Interview

Your contact information

First Name

Last Name

Email

Phone Number

Zip code where you live

Comments

Appendix 3: Promotional Flyers

CALLING ALL FAMILIES!

Parents, guardians, and kids 12 and older, please join us to share your experiences and ideas.

Virtual Community Listening Session
December 12, 2020
11-12:30 p.m.

Join us for an important conversation about the impacts of the pandemic and recent events on behavioral health.

Click Here to Register

Each year, the County of San Diego Behavioral Health Services collects community feedback about the behavioral health of San Diegans through a variety of activities including public community listening sessions, focus groups, and interviews. Feedback is used to inform program planning, and results are published annually in the Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan and Annual Updates.

LIVE WELL SAN DIEGO | COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

For questions or if you would prefer to participate in a one-on-one interview, please contact Martha Crowe at mcrowe@sdsu.edu

To learn more and to register visit listentosandiego.org

SAN DIEGO STATE UNIVERSITY
Institute for Public Health

CALLING ALL BEHAVIORAL HEALTH SERVICE PROVIDERS!

Do you provide mental health or substance use treatment services in San Diego County?

Virtual Community Listening Session
December 1, 2020
10-11:30 a.m.

Join us for an important conversation about impacts of the pandemic and recent events on behavioral health

Click Here to Register

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To learn more and to register visit http://listentosandiego.org/

SAN DIEGO STATE UNIVERSITY
Institute for Public Health

Appendix 4: Media Buys, Advertisements

SHEEP AND GOATS

I ANSWERED THE CALL

Westminster Presbyterian Church

Contact: *3598 Talbot Street, San Diego 619-223-3193* www.westminstersd.org
Membership: *100*
Pastor: *Megan Cochran*
Neighborhood: *Point Loma*
Age: *34*
Born: *Albert Lea, MN*
Formation: *Macalester College, St. Paul, MN; McCormick Theological Seminary, Chicago*
Years Ordained: *7*

San Diego Reader: *What is your favorite subject on which to preach?*
Pastor Megan Cochran: God is bigger and more creative and more loving than we can ever imagine. We are being called to be loving and creative people in the world. That message is always relevant. At Westminster, we talk about how we can help God to co-create a world that if filled with justice and joy for everyone, especially those the world harms.
SDR: *Why Presbyterian?*
PC: I always talk about the Presbyterian Church by saying it is a church of grace, gratitude, and grit. Grace is a free gift before anything else. In life we are loved by God, and there's this gritty aspect where we are committed to social justice and fighting for creating a world that Jesus was trying to create. Also, in gratitude, our whole lives are an incredible response to this gift from God…. I can't imagine being anything but "Presby" now. This is my place; these are my people.
SDR: *What is the mission of your church?*
PC: At Westminster, we're the place where art, faith and nature meet. We are seekers creating a just and joyful community where all have a place at God's table. We are the first "More Light" Presbyterian church in San Diego. That means we are open, affirming and inviting to the LGBTQ community. We have a thriving theater community here; we have a pre-school; we have four acres of land in Point Loma. So we have a playground, a community garden, and a park. It is really this totally incredible place where we are creatively trying to live into the future of what it can mean to be the church.
SDR: *What one book has had the most impact on your ministry?*
PC: I love art. Madeleine L'Engle has this book called *Walking on Water*, which talks about the connections between art and faith. That has profoundly impacted my journey as a pastor. In addition to literature, artwork for me – of all kinds – is informative for me as a pastor. Georgia O'Keefe is one of my favorites. Anytime people are being creative, the church can learn something from that. Because we believe in a creative God, we are all called to be creative beings



Megan Cochran

in the world. L'Engle gives permission to all of us to consider ourselves artists. Art can look different for everyone; for some it might be a painting; for some it might be an Excel spreadsheet. Whatever way you are creating and bringing about connections in the world, that is you being an artist. For L'Engle and for me, that is a faithful process.
SDR: *Where do you go when you die?*
PC: I don't know where we go when we die. But what I do know and deeply believe is that nothing in life or death can separate us from the love of God. This wild mystery that holds us in life will surely hold us in death also. I am so grateful for the bigness and graciousness of God. If you're asking me personally, do I believe in hell…probably not. But there is a lot I don't know about the world, and this is one of those moments where I think, "Thank God that God is God and I am not."

- Joseph O'Brien

Find more Sheep and Goats columns at SDReader.com/worship/

Musical Theatre Day Camps STAR Repertory Theatre is offering Live In-Person Theatre Day Camp Programs weekly with three different age groups between 5 to 16 Monday-Friday. Each camp is 1 week featuring shows such as: Beetlejuice, Hamilton, Hairspray, Backstage Tech, SIX, Matilda, Grease, 13, Heroes/Villains, Improv, Wicked, Annie, Frozen, Seussical, Disney. Twelve campers only per camp due to COVID-19 restrictions. Mondays, 1pm; through Friday, December 18, $195-$550. Star Repertory Theatre, 329 East Valley Parkway. (ESCONDIDO)

Virtual Roots: Egypt Tune in live on the San Diego Children's Discovery Museum Facebook page to enjoy a traditional dance performance, bilingual storytime in Arabic and English, and other cultural activities. Check the page for the Roots: Egypt video and give us a follow to be notified when it goes live. Activity kits are available while supplies last. Tuesday, December 8, 4pm; **free**. https://bit.ly/3ljMMMf. (ONLINE)

LECTURES

ArtTalk with Ariel Quartet: Celebrating Beethoven Join members of Ariel String Quartet in conversation as we celebrate the 250th anniversary of Ludwig van Beethoven's birth.The quartet will share stories of how they approach the composer's music and why it is still as vital today as it was two centuries ago. This event is free with registration. Saturday, December 5, 10am; **free**. artpower.ucsd.edu/event/ariel-arttalk/. (ONLINE)

Endangered Orcas: The Story of the Southern Residents These urban orcas, a Pacific Northwest icon, are at the center of human politics as we attempt to learn from the past and find a sustainable future. This presentation is free and open to the public. Wednesday, December 9, 7pm; **free**. acssandiego.org/upcoming-speaker.php. (ONLINE)

How Nature Lovers Survive COVID on Mt. Whoville Kati and Ernie transformed their 1.5-acre parcel into a nature sanctuary. They provided water and planted friendly plants that interface with the native chaparral environment, allowing wildlife to bloom. COVID lockdown has allowed them to spend more time at home enjoying and observing visitors. Their photography includes game cameras and an intimate nest camera to see night visitors. Friday, December 4, 7pm; **free**. https://bit.ly/3qdYyvp. (ONLINE)

How Not to Destroy the World with AI The third annual lecture of the Institute for Practical Ethics at UC San Diego, featuring a presentation by Dr. Stuart Russell: Dr. Stuart Russell, professor of computer science at UC Berkeley, is a global expert in artificial intelligence. While some developments in AI are enormously positive, others, such as autonomous weapons and the replacement of humans in many real-world, decision-making scenarios, may be negative. Should this be a cause for concern, as Elon Musk, Stephen Hawking and others have suggested? Prof. Russell will argue that the problem is real, and the technical aspects are solvable, IF we replace current definitions of AI with a version based on real benefit to humans. Thursday, December 3, 4pm; **free**. https://bit.ly/33rC4gp. (ONLINE)

Living Room Lecture: Avian Remains from the Presidio Very little is known about chicken husbandry in colonial America, which makes this study the first comprehensive analysis of chicken remains in North America. Chickens are scarcely mentioned in historical accounts describing early California, and information on their sex, age, or management is rare. Small-scale poultry production, likely managed by women and children, provided California presidios with a form of subsistence independence. This virtual event will be held on Zoom. Thursday, December 3, 5:30pm; **free**. https://bit.ly/39ru2Iw. (ONLINE)

Saidiya Hartman Guest Lecture University of California San Diego presents Saidiya Hartman, a scholar of African American literature and cultural history whose works explore the afterlife of slavery in modern American society and bear witness to lives, traumas, and fleeting moments of beauty that historical archives have omitted or obscured. She weaves findings from her meticulous historical research into narratives that retrieve from oblivion stories of nameless and sparsely documented historical actors, such as female captives on slave ships and the inhabitants of slums at the turn of the twentieth century. Friday, December 4, 12pm; **free**. https://bit.ly/3ljhLbj. (ONLINE)

MARKETS

San Diego Vintage Collective Market Outdoor holiday market with San Diego's finest vintage vendors and local makers. Shop 1000s of products from 80+ vendors, clothing, home goods, art, jewelry, accessories, etc. San Diego Vintage Collective is an outdoor market within walking distance to SD's best restaurants, shops, and hotels. This event follows cdc social distancing guidelines and masks are required for entry. Sunday, December 6, 10am; **free**. Arts District Liberty Station, North Promenade, 2875 Dewey Road. (LIBERTY STATION)

SPOKEN WORD

2020 Virtual Memoir Showcase Ten winning stories will be performed by professional actors and actresses and livestreamed on Facebook, with the 2020 Theme: That's a Terrible Idea, What Time? From wearing a Glinda the Good-witch Costume to a Wedding, Braving a Jungle filled with Howler Monkeys, to having lunch with your husband's lover, this year's showcase will also feature a presentation by The Ajumma Experience, a local Korean flash mob dance group. Saturday, December 5, 7pm; **free**. 18 and up. facebook.com/sandiegowritersfestival/live. (ONLINE)

PARENTS, CAREGIVERS, AND YOUTH 12 AND OLDER, PLEASE JOIN US TO SHARE YOUR EXPERIENCES AND IDEAS!

Virtual Community Listening Session

December 12, 2020 • 11am to 12:30pm

Join us for an important conversation about the impacts of the pandemic and recent events on behavioral health.
Youth can earn two hours of community service for attending.

Visit www.ListenToSanDiego.org for more details and to register.

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO LIVEWELLSD.ORG | SAN DIEGO STATE UNIVERSITY Institute for Public Health

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LIVE WELL SAN DIEGO LIVEWELLSD.ORG

SAN DIEGO STATE UNIVERSITY Institute for Public Health

Community masking, the right question?

By Jessica Brodkin Webb
STAFF WRITER



The face mask has come to symbolize a political divide between citizens who say the practice infringes on their personal rights and people who believe they are looking out for everyone around them based on Centers for Disease Control and Prevention directives dating back to April 3.

Does an unspoken social contract with society demand we cover up and politely distance or does individual freedom supersede the collective need?

Southwestern College Philosophy Professor Peter Bolland said he believes the argument that wearing a mask is merely a 'personal choice' is a juvenile misunderstanding of what liberty really means.

"Liberty does not mean doing whatever you want as if you exist in a bubble. No right is absolute. Rights are always married to responsibilities," Bolland said.

He takes issue with politicians who frame the practice of wearing a mask as being done out of fear and said he is "baffled" that a question of science could be converted to an argument on whether wearing a mask is a personal choice.

"One of the themes that has been a through line in all this: we've seen an erosion of faith in expertise. There's this sense that we're not to trust educated people, that there's no difference between One America News and the New York Times and I don't know how to combat that because you can't offer evidence to conspiracists," Bolland said.

His concern is that "once we start insisting it's all fake, it's all fake, it's all fake— that infects the debate about masks. It's frustrating that we aren't relying on the best scientific evidence," Bolland said.

Grossmont Philosophy Professor Leila Parello is less worried over whether asking people to wear a mask has legal weight and is more concerned with what the directive to distance might mean for the nation.

She is especially concerned that the practice of education is being rapidly and negatively affected by mandating student distancing and relying on distance tools for learning.

"If students are kept away from each other indefinitely, it could grow to be an enormous handicap— learning and knowledge have a great deal to do with being able to coordinate yourself amongst the objects in space and time, not just looking at a screen and dealing with a representation of a representation," Parello said.

Because learning online is done primarily through the use of a program that she said "is in itself a filter," online learning requires students to behave and respond a certain way, removing the freedom to interpret or imitate reality like they would do in person.

Imitation is required to truly learn, Parello said, a concept she says "philosophically goes all the way back to Plato and the imitative art".

She worries the ability for people to independently think and develop is going to be curtailed if students cannot interact in person.

"If you can't imitate writing you can't write a sentence; if you can't write then you can't read; if you can't read you can't interpret things in the world around you. Language is the root of everything, the genesis of everything. Without language, we don't have the ability to approximate the truth of anything," Parello said.

Like Bolland, she is concerned the American public does not distinguish between science and hyperbole. She personally questions whether the American public is being given the entire truth but says the fact that there is widespread mistrust is in itself concerning.

"We're mandating behaviors that insert mistrust into civilization and once we do that, how do we get rid of it? Once you change the structure of civilization and communication, it is hard to undo those changes, to go back to trusting," Parello said.

Secular Humanist Jason Frye leads a group of about 30 to 40 philosophers in a weekly talk. Frye said he and fellow humanists "think of the philosophy behind why a lot of people act in certain ways and examine things in a deeper sense, like cognitive science."

He said his background in Political Science coupled with that humanist outlook provide for a nuanced answer.

"The more liberatarian perspective would say we have to place individual freedom above everything else. The idea is 'If I don't want to wear a mask, nobody should force me' but that's incredibly short-sighted because basic cost analysis would suggest that even if you don't catch it yourself, the virus is going to be running rampant and from a public health standard there will be shutdowns. So, if you don't participate in wearing a mask, it will take longer to get back to normal. Therefore, if you want your life back, wear a mask," Frye said.

He then pivoted and approached the question from a social science standpoint.

"To say it's just ourselves against everyone else is a rather impoverished way of looking at the world, impoverished in the regard that we know from psychology, from philosophy and from our own experience that we find our greatest meaning in relationships with other people and we want to have our friends and family around us in great health for a long period of time. Therefore, if we want to see our friends and family members safe, not catching this virus, wear a mask," Frye said.

Finally, he approached the question as a political one.

"In terms of patriotism, if we want to consider ourselves patriotic, we have a duty to be good community members and to maintain our parks and civic resources, a duty to influence good behavior on younger people and a duty to do our part and secure a better future for our country together. Part of that duty is to help the health of our nation, therefore wear a mask," Frye said.

Ultimately, he said, a society only works when everyone keeps everyone else in mind. Like Parello, he said suspicion and mistrust lead to the downfall of society.

"If you want to place a value on everything, which we as people do inherently, a society with trust and volunteerism and care is far more valuable than a society with suspicion and anxiety because that is not a world anyone values enough to want to live in," Frye said.

Regardless of how one gets to the endpoint of their reasoning, Frye said, all the paths come back to the fact that we're far less likely to contract COVID-19 or pass it on to others if we are masked.

Where Parello made the dis-

SEE MASKS, PAGE 5

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City launches small business campaign

By Albert H. Fulcher
MANAGING EDITOR

In response to the difficult times that small businesses are facing with the COVID-19 pandemic, the city of Chula Vista is asking people to think big and shop small, launching its We built THIS campaign, which began on Small Business Saturday.

City of Chula Vista economic development specialist Miranda Evans said the We built THIS small business campaign is one of the city's economic initiatives it has been working on during the pandemic.

"This is a social media-driven campaign that launched Small Business Saturday and we will be running it through the holiday season, promoting the importance of supporting our small businesses in Chula Vista. Once we get past the holidays, we will continue the campaign through the end of June 2021," she said.

The campaign's purpose is to shine a spotlight on the importance of supporting community over convenience, said Evans. She said it might be easier to shop online retailers, but it does not make a positive difference in the community.

"When you shop small at these amazing businesses we have in our city, you are supporting a neighbor, a family member or a friend," said Evans. "You are helping them get their kids through college, putting food on their table. So many of our entrepreneurs are hard workers. Their livelihood is completely tied up in their business and every one of them have been severely impacted by COVID. We want everyone in the community to feel community pride and as cheesy as it is, we are all in this together. If we want the small businesses to come out of this, we all have to do our part."

Evans said small businesses with 10 or fewer employees compromise 95 percent of all businesses in Chula Vista.

"They are so important," she said. "They are really the heartbeat of our community. They add amazing diversity and richness to our community, and we have those small entrepreneurs to thank."



Chula Vista Mayor Mary Casillas Salas said the city has witnessed the passion and creativity of local businesses that had to quickly adapt during the challenges of the pandemic in a press release.

"It's crucial for our community to embrace and support our local businesses, now more than ever before, by shopping local throughout the holiday season and beyond," she stated.

This initiative includes a visual journey into Chula Vista businesses, which features opportunities to tune into videos, follow on social media, explore shopping districts and discover the variety of small businesses operating within the city.

For more information visit www.explorechulavista.com.



Contest a bright, profitable idea

By Jessica Brodkin Webb
STAFF WRITER

The city of National City is hosting their inaugural holiday home and business decorating contest, themed the Bright Lights of 2020 for this year.

Anyone interested in participating will need to register for the contest then submit photos of their decorated home or business exterior to the city.

The contest is spearheaded by National City Mayor Alejandra Sotelo-Solis with prizes sponsored by Westfield Plaza Bonita for a home category and a business category.

"We want to invite our community to decorate and show their holiday spirit! It will be a way to celebrate the end of this challenging 2020 year," Sotelo-Solis said.

When they register for the contest, participants can have their address included or left off the Bright Lights city map that will be made available online for people to follow on a self-led tour of decorated exteriors.

Photos of contest entries must be sent to National City mayoral assistant Nancy Valdivia-Ochoa at nvaldiviaochoa@nationalcityca.gov and must be received by 5 p.m. Saturday, Dec. 5.

Judging will occur Dec. 5 through 8.

First-place winners will nab $150, second-place winners will receive $100 and $50 will be given to each third-place winner. Call (619) 336-4284 for more information or visit www.nationalcityca.gov to register for the contest.

Parents, caregivers, and youth 12 and older, please join us to share your experiences and ideas!

Behavioral Health Services
Virtual Community Listening Session
December 12, 2020
11am to 12:30pm

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BURGLAR

CONTINUED FROM PAGE I

not know the resident whose home was burglarized.

The DA's office objected to Gil's parole. The Department of Corrections has been releasing nonviolent inmates in part because of the spread of COVID-19 in prisons and overcrowding.

"It should be noted that great weight was given to the fact the inmate Gil has no history of any violent felonies," stated a ruling by the Board of Parole hearings.

"Inmate Gil does not pose a current, unreasonable risk of violence or a current, unreasonable risk of significant criminal activity and is approved for release," the ruling says.

The ruling says Gil had no violations of rules resulting in physical injury or threat of injury to others while in prison. It mentions Gil's "physical and cognitive limitation and the totality of the circumstances of the case factors."

Gil and Preciado were arrested by San Diego Police on Sept. 6. Gil remains in the central jail while Preciado is housed in the George Bailey Detention Facility. There is a warrant for Preciado's arrest from another county, so he cannot post bail.

The hearing was held remotely with the attorneys and witnesses speaking via computer cameras. The defendants appeared on video feeds from jail.

READY

CONTINUED FROM PAGE I

was designed to develop a future workforce based out of South San Diego county and was created in a partnership with the Live Well San Diego South Region Leadership Team, Logan Heights Community Development Corporation, Metropolitan Area Advisory Committee on Anti-Poverty of San Diego, Junior Achievement, South Bay Community Services, Institute for Public Strategies, and South County Economic Development Council.

Additional program support is provided by the Small Business Development Center, RISE San Diego, San Diego Council on Literacy and the county of San Diego Department of Health and Human Services.

For more information or to submit an application, visit: https://www.nationalcitychamberfoundation.org/i-m-ready.

CALFOCUS: LA MESA

Generating ideas to power through East County wildfires

By Jessica Brodkin Webb
Staff Writer

It took almost 20 days to completely extinguish the September Valley Fire that burned 16,390 acres, plenty of time for East County residents to consider purchasing a backup generator capable of maintaining their power supply in times of emergency.

Bay City Electric Works Vice President Austin Lee, whose company supplies generators to dealers throughout California for commercial and industrial installation said most of San Diego county has what he calls a reliable grid but East County stands out with a specialized need for sustainable power when wildfires hit the area.

"In East County, where wildfires are more of a risk, power has been shut down more regularly over the past few years. Residents learn really quickly about their needs. Two of the most common needs in the area are power for a well pump for agricultural needs and horses, and baseline power for medical needs," Lee said.

Triple S Electric owner Jeff Simonides is an electrical contractor who installs generators; he is also an East County resident who is familiar with the planned and unplanned power outages that he believes are more frequent in this part of the county.

"A lot of the homes out here have sprinkler systems that won't work unless they have power," Simonides said.

He also mentioned adequate lighting for elderly residents as top of his list, and said animals needing water is a huge concern.

"Backcountry residents are on a well and without power, those wells aren't going to work which means people growing anything or keeping animals are completely without water. Animals are always a victim of our poor planning," Simonides said.

Alpine resident Richard Edwords works as an Account Executive at Kamp's Propane and said he has seen an increase in locals purchasing propane to power a generator, one indication that residents have learned from wildfire incidents but has also noticed customers skimping on generators that ultimately harm computerized appliances.

"One of the things that's affecting a lot of my customers is they're buying cheaper, portable generators that are surging. The Hertz, which is how we measure frequency are a little off-tilt. If that frequency is off, it can damage your power supply. It's especially important for Energy Star appliances that have computers," Edwords said.

Another issue he frequently sees are customers who load too many appliances on one circuit. He compared the situation to a car that comfortably runs at 70 miles per hour.

"A generator should be run at 70% load. If you require 10,000 watts of power, you don't want to buy a 10K generator or you'll overload. It would be like running a car at full throttle all day long. Buy bigger and run your generator comfortably," Edwords said.

Lee also said anyone thinking of hiring an electrician to install a full generator system needs to keep future growth in mind.

"Things have changed— people have multiple devices, laptops, cellular phones, people and businesses are working from home. We're looking at the future, people buying electric cars, these social changes are driving awareness of a backup system," Lee said.

Just as coastal homes from 25 years ago didn't necessarily include air conditioning, Lee said, homes today don't necessarily include a generator but it is becoming part of the conversation as wildfires arise more frequently.

Lee said even in East County, the size and type of generator can be different from neighborhood to neighborhood because of local sound requirements for fully installed generator systems.

"If you have three acres in Lakeside and you can't see your neighbors house that's one thing; in La Mesa a permanently installed system, about the size of two air conditioning units that will come on automatically when the power goes off might involve different permits because something that size is going to have different requirements due to sound," Lee said.

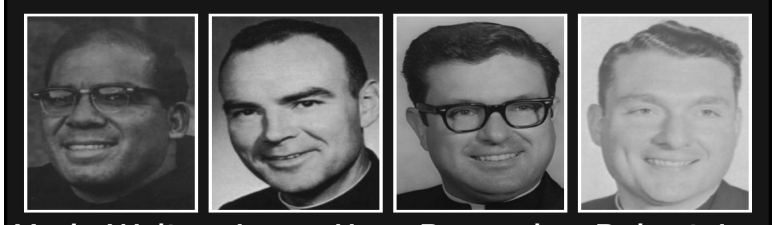
Simonides said he is a regular electrical contractor and doesn't push people to buy generators but he has increasingly taken on generator installation projects over the past year and sees the need, often bringing up 'what-if' situations that customers don't consider.

"For example, I run into customers who have an electric gate. Without power, there is no way for them to get out of that gate or for the fire department to get in. We always put that on

SEE GENERATOR, PAGE 5

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Transit district to upgrade railroad signaling equipment

By Dan Brendel

DEL MAR — The North County Transit District (NCTD), a public agency, will soon upgrade certain railroad signaling and monitoring equipment, some for the first time in decades, though plans for future capital replacement remains uncertain.

NCTD aims to deploy the majority of $33 million of federal, state and local grants over the next several years toward upgrading train and crossing control systems. Such systems include signals, switches, gates, bells and lights.

The district also plans to install wireless monitoring and emergency communications equipment in Del Mar and near Miramar, though it hasn't yet identified funding for this project.

NCTD, governed by North County elected municipal officials, operates rail, bus and shuttle services. Its FY 2020 operating budget weighs in at $117 million. About three-quarters of its operating revenues come from federal, state and local subsidies, the remainder from passenger fares and other generated income.



NORTH COUNTY Transit District also plans to install wireless monitoring and emergency communications equipment in Del Mar and near Miramar. *File photo*

"A lot of these projects will be the first … we've done on the Coaster [a regional commuter] corridor since we purchased it from BNSF." In 1992, NCTD Executive Director Matthew Tucker told the board of directors at its Nov. 19 meeting, "I'm hoping that the next time we have to deal with this is 15 to 20 years from now."

"Some of the equipment has been upgraded as part of specific projects," but this, "Will be the first … corridor-wide approach to signal modernization," NCTD spokeswoman Kimy Wall told The Coast News.

Regarding planning for the next round of capital replacement, Tucker said, "The key is going to be … knowing what the [equipment] vendors are doing," in terms of fielding new technology. "Then hopefully [we'll have] enough time to be able to fund it."

"NCTD has more than $1 billion in unfunded capital needs," Wall said. "NCTD, like all transit agencies, does not receive sufficient funding to complete all replacement and state-of-good-repair projects along the optimal replacement schedule. Accordingly, NCTD must prioritize capital expenditures."

However, "NCTD conducts condition assessments and preventive maintenance activities to ensure that all assets can be safely operated within regulatory requirements," she said.

The Coaster's crossing and train control systems are 71% and 45% obsolete, respectively. The Sprinter line uses 1990s technology, according to Signal Manager Zachary Taylor

"Obsolete does not mean unsafe," but rather the equipment "Is no longer supported by the manufacturer… they're no longer creating spare components," he said. In upgrading systems, NCTD hopes to move "Towards predictive analytics," using data to forecast "problems before they occur."

NCTD plans signal upgrades at numerous locations, including nine in the Carlsbad area in 2022 and two in Encinitas and Del Mar in 2023.

Wireless equipment installed near Del Mar and Miramar would complete a systemwide network for monitoring the tracks and communicating with railcars in the event of an emergency.

Del Mar and Miramar are, "Two critical safety areas where we need more camera visibility," Tucker said. "Oftentimes at Miramar, if we're having a significant rain event, we're having to deploy someone to stand out there."

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Escondido council OKs bike park named for Masson

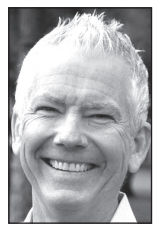
By Tigist Layne

ESCONDIDO — The Escondido City Council met on Wednesday, Nov. 18, and approved funding to build the John Masson Memorial Bike Park inside of Jesmond Dene Park. The council also heard from outgoing Councilmember Olga Diaz as she reflected on her three-term tenure on the council.

The council approved using $271,303 in Prop 68 Per Capita grant funds to build the bike park, which will be named in honor of the councilmember who passed away in March. The park will be located in Masson's district and near his home.

Diaz became emotional during the meeting as she remembered Masson and spoke of how appropriate it is to be honoring him with a project he'd be passionate about.

"He was such a big part of the spirit of the city, and his work on skate spots and the bike park idea, these were his passions," Diaz said. "I think he would be proud to know that we're taking this action and making this investment."



MASSON

Mayor Paul McNamara also spoke about Masson and emphasized his enthusiasm for the city.

"He was our friend … his enthusiasm for Escondido and trying to move it forward in the right direction was contagious and genuine. We all miss him," McNamara said.

According to the staff report, the bike park will require environmental review, Planning Commission consideration and final City Council approval before it can be incorporated into the Jesmond Dene Park Master Plan.

Staff will return to the council in January 2021 for final approval.

The council then heard from Diaz, who will be leaving City Council in a few weeks after serving three terms on the council.

Diaz said that she chose to step away to give other city residents a chance to lead and to also give herself time to refresh her perspective on what truly matters.

"I ran for office in 2006 to push back against racist, anti-immigrant and xenophobic policies … even though I lost, I didn't quit," Diaz said.

In 2008, Diaz ran again and won, beating a two-term incumbent and becoming the first Latina elected in the history of Escondido.

Diaz went on to thank a handful of her mentors, colleagues, friends and supporters. She reflected on her years on the council when she was the only Latina, the only Democrat and the only woman.

The councilwoman also noted the issues she has supported during her time on the council including smart growth, climate action, public parks, public services, youth engagement and the Escondido Creek Restoration.

The staff then read several comments from the public wishing Diaz well and thanking her for her years of service. The other councilmembers and the mayor also shared words of gratitude and admiration for Diaz.

Diaz said that along with her work on several nonprofit boards and ongoing work at a local college, she will be starting a doctoral program at University of Southern California.

The installation ceremony for the new council will be held Dec. 9.



MORE THAN 30 cats were taken in by the San Diego Humane Society after being abandoned in Escondido. *Courtesy photo*

Humane Society rescues 30 cats

By City News Service

ESCONDIDO — More than 30 cats were taken in by the San Diego Humane Society after they were left behind inside a condominium in Escondido last month, the agency announced Nov. 18.

The property manager of a condominium complex in the 1000 block of East Washington Avenue called the group on Oct. 22 to report that one of the condo's tenants had abandoned the cats after being evicted, according to the SDHS.

Officers from SDHS' law enforcement division responded to the home and found 31 cats living in "unsanitary conditions" inside the unit, SDHS spokeswoman Nina Thompson said.

The cats were taken to SDHS campuses in Escondido and Oceanside for extensive medical exams, Thompson said.

One cat had to be euthanized and a majority of the cats were found to be suffering from numerous medical conditions, including upper respiratory infections, diarrhea, ear infections and heart murmurs.

Fishing licenses available

By Staff

REGION — California anglers can now purchase 2021 fishing licenses and related items directly through the California Department of Fish and Wildlife (CDFW) website or authorized license agents.

Due to the COVID-19 pandemic, license sales counters at CDFW offices remain temporarily closed to the public. The cost of a 2021 annual resident fishing license has been set at $52.66, while a one-day license will cost $17.02. For the first time, anglers have the option to sign up for auto-renewal of their annual sport fishing licenses, report cards and validations.

"More than a million anglers purchase annual licenses to fish California waters and for many of them, this will be a welcome feature," said Josh Morgan, chief of CDFW's License and Revenue Branch. "Signing up for auto-renewal helps ensure that you won't end up on the water with an expired license."

Anglers must enroll in the auto-renewal program through CDFW's online sales website. License agents cannot enroll customers in the auto-renewal program, but customers who make purchases in person from license agents can go online later and enroll themselves.

Not all CDFW products for sale are eligible for auto-renewal at this time, although the feature will be expanded to other items in the future. For more information and a complete list of items available for auto-renewal, refer to the Frequently Asked Questions about auto-renewal on CDFW's website.

Who's NEWS?

Business news and special achievements for North San Diego County. Send information via email to community@coastnewsgroup.com.

ON STAGE

Emily Midgley, of Carmel Valley, recently participated in Hamilton College's Fall Main Stage Production of "In War With Time, From the Sonnets of William Shakespeare" as a member of the cast. The partly live and partly recorded production was presented on YouTube and included a cast of 13 Hamilton students and alumni performing a collection of Shakespeare's sonnets.

PICKLEBALL HALL OF FAMER

Alex Hamner, a 30 year Carlsbad Resident was inducted into the 2020 "Pickleball Hall Of Fame" Competitor category. Alex has compiled 21 gold medals at USAPA Nationals, US Open Pickleball Championships and Tournament of Champions.

STOP THE SCAMS

As the shopping season gears up Utility Scam Awareness is being highlighted. SDG&E joined electric, water and natural gas utilities to educate customers about utility imposters who prey on people's reliance on essential services to cheat them out of money. With more people staying at home or possibly facing financial difficulty, scammers try to take advantage of the situation. Visit https://sdgenews.com/article/sdge-joins-national-campaign-raise-awareness-utility-imposter-scams for more information on common scams we see and what customers should do to protect themselves.

NEW CORK & KNIFE

Slated to open in Escondido in late November, Cork & Knife 515 West 13th Ave, Escondido is a small production wine store that will offer close to 100 varieties of vino. browse the selections of wine artisan meats and cheeses either in person, or on Cork & Knife's website, Cork & Knife will be open Tuesday through Sunday, from 11:30 a.m. to 8 p.m., with outdoor seating. There will also be a second location opening in Rancho Santa Fe, as part of Nick & G's, at 6106 Paseo Delicias.

HONORS FOR SAN MARCOS

North San Marcos recently received top honors from the California Association for Local Economic Development with an Award of Excellence for its innovative, collaborative foundation and creation. Each Tuesday afternoon, the streets of North City offer live music, artisans, food vendors, flowers and fresh fruits and vegetables at the weekly Farmers Market, run by the San Marcos Chamber of Commerce.

IRRIGATION EXCELLENCE

Vista Irrigation District has been presented with the Certificate of Achievement for Excellence in Financial Reporting by the Government Finance Officers Association of the United States and Canada for its comprehensive annual financial report for fiscal year ending June 30, 2019. This certificate is the only national award for public sector financial reporting.

BOYS & GIRLS CLUB GRANT

The Boys & Girls Clubs of Oceanside has received a $10,000 grant from the Rest Haven Children's Health Fund for our Food and Snack Program. As school closures continue, this much needed program provides nutritious lunches and snacks to youth attending BGCO's Back2School Program.

OMWD BUSINESS OF YEAR

Olivenhain Municipal Water District recognized at its Nov. 18 board meeting nine individuals and businesses making a significant, positive impact over the last year in the community, the San Diego region, or local water systems. D&H Water Systems was recognized as Business of the Year for its critical part in recent upgrades to systems at OMWD's David C. McCollom Water Treatment Plant.

GIFTS FROM LOCAL ARTIST

Encinitas artist Wade Koniakowsky has created reversible Tote Bags with tropical-inspired texture and color right out of Koniakowsky's favorite paintings. The other side is a warm and calming wave scene. Shop at koniakowsky.com/.

FIGHTING LITTER

The SANDAG San Diego Regional Litter Abatement Subcommittee, met virtually for the fifth meeting to support litter reduction on the region's transportation corridors on Nov. 18. The San Diego Regional Litter Abatement Subcommittee provides input and guidance to the SANDAG Board of Directors on future actions and policies to support the reduction of litter in the region. The meeting included a presentation from California Highway Patrol Sergeant Kyle Johnson, with an overview of the agency's operations, response and enforcement statistics, and procedures.

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Resguardo por tierra y mar

SAN DIEGO.- Cada día, más de 140 personas aproximadamente intentan ingresar ilegalmente a Estados Unidos por algún tramo de la frontera que divide a San Diego de Baja California.

De acuerdo al año fiscal 2020, que comprendió del 1 de octubre de 2019 al 30 de septiembre del presente año, agentes de la Patrulla Fronteriza del Sector San Diego detuvieron a 53,282 personas por haber ingresado ilegalmente a territorio estadounidense.

Aunque la cifra se cuenta por miles, esto representó una disminución del ocho por ciento comparado con el año fiscal 2019, donde los agentes aprehendieron a 58,049 personas.

Según el reporte de la Patrulla Fronteriza, las capturas de menores no acompañados que ingresaron ilegalmente Estados Unidos se redujeron un 44% comparado con el periodo anterior ya que se realizaron 1,855 encuentros en todo el año fiscal 2020.



Noventa y seis kilómetros de la frontera terrestre es lo que diariamente resguardan 2 mil 100 agentes de la patrulla fronteriza en el Sector San Diego. Foto José Antonio Avilés

Detenciones y decomisos en un año por la Patrulla Fronteriza

ATAQUES CONTRA AGENTES

Los agentes no están exentos de riesgos al realizar su labor porque ocurrieron 54 ataques contra ellos durante el año fiscal 2020.

Independientemente de las agresiones, los oficiales llevaron a cabo 45 operativos de rescate en el último año, lo cual representó un aumento del 125% con respecto al año fiscal 2019.

"En medio de la confusión, la incertidumbre e incluso las pandemias globales, nuestros agentes se presentan y hacen el trabajo", señaló en un comunicado Aaron M. Heitke, jefe de la Patrulla Fronteriza.

De acuerdo a la autoridad, esta cifra no incluyó las innumerables llamadas de ayuda de personas que se encontraban en una situación de peligro las cuales se reportan diariamente.

RECORD EN DECOMISOS

Los agentes fronterizos decomisaron cantidades récord de fentanilo y metanfetamina en un año.

Las 383 libras de fentanilo incautadas en el año fiscal 20 representó un aumento del 255 por ciento de las estadísticas del año fiscal 19 (107 libras).

383 libras de fentanilo *incautadas en el año fiscal*

Las 7.169 libras de metanfetamina incautada reflejó un incremento del 83 por ciento.

"Estoy orgulloso de todos los hombres y mujeres que protegen nuestra nación aquí en el sector de San Diego", recalcó Heitke.

TRAFICO MARITIMO

Agentes del Sector San Diego en conjunto con elementos del Departamento de Seguridad también registraron un número récord de intentos de contrabando marítimo (309) y un número récord de aprehensiones en el mar (1.273).

El contrabando de personas por mar es peligroso ya que suele consistir en el ingreso ilegal de más de una docena de migrantes en barcos pesqueros de casco abierto llamados pangas.

Todos los días, dos mil cien agentes de la patrulla fronteriza en San Diego vigilan noventa y seis kilómetros de la frontera terrestre así como 114 millas náuticas.

José Antonio Avilés
Ellatinoonline.com



El contrabando marítimo de personas es considerado peligroso. Foto archivo CBP

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Sesión virtual para escuchar a la comunidad
12 de diciembre de 2020
11:00 am a 12:30 pm

Les invitamos a que participen en una plática sobre los impactos de la pandemia y los más recientes eventos en la salud del comportamiento. Los jóvenes pueden obtener dos horas de servicio comunitario por asistir.

Visite www.ListenToSanDiego.org para obtener más información y para registrarse.

Cada año, los servicios de salud de conducta del condado de San Diego recopilan comentarios sobre la salud de conducta de los habitantes de San Diego a través de una variedad de actividades que incluyen sesiones de escucha de la comunidad pública, grupos de enfoque y entrevistas. Los comentarios se utilizan para informar la planificación del programa, y los resultados se publican anualmente en el programa de tres años de la Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés) y el plan de gastos y las actualizaciones anuales.

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Se triplicaron las **hospitalizaciones por Covid 19 en el condado**

Autoridades de Salud en el condado de San Diego informaron que las hospitalizaciones por el Covid 19 se triplicaron en el último mes, y advirtieron que el número todavía se proyecta a duplicarse en unos 38 días.

Los hospitales en el condado de San Diego tienen ahora el triple de los pacientes por Covid 19 que tenían en los primeros días de noviembre, y anticipan que para la primera quincena de enero tengan seis veces el total de internados que había am principio de noviembre.

El incremento que se espera para los próximos días proviene de reuniones familiares y con amigos que muchos sandieguinos celebraron en el Día de Acción de Gracias, pese a peticiones oficiales de abstenerse de viajar y de reuniones.

La doctora Wilma Wooten de la Agencia de Servicios de la Salud en el condado, exhortó a que todas las personas que viajaron y las que se reunieron para cenas de Acción de Gracias se hagan cuanto antes pruebas para detectar el Covid 19, aun aquellas personas que no sienten ningún síntoma.

"Al hacerse la prueba, las personas sabrán si han contraído COVID-19 y evitarán la propagación del virus a otros", dijo la doctora.

> *"Al hacerse la prueba, las personas sabrán si han contraído COVID-19 y evitarán la propagación del virus a otros"*

Las hospitalizaciones en el condado de San Diego comenzaron a aumentar a partir del 17 de noviembre, pero se han disparado a partir de Acción de Gracias.

También las infecciones han aumentado. Al cierre de este número de El Latino iban más de 20 días en que los nuevos casos positivos no bajaban de 600, y en los últimos días solo fluctuaban en 1,800 nuevos contagios diarios.

Sin embargo, los fallecimientos por Covid 19 se mantenían relativamente estables.

Desde la última semana de noviembre y hasta el primero de diciembre el número total de fallecimientos por contagios se acercaba a la barrera de las 1,000 muertes pero sin llegar a esa cifra. El total de fallecimientos al cierre de esta edición continuaba en 997 por tercer día consecutivo.

En lo que va de la pandemia, se han registrado 84,043 casos positivos de Covid 19, de acuerdo con cifras oficiales. De ese total, el 5.6 por ciento –4,635 personas—se han tenido que hospitalizar, y de ellas 1,019 pacientes tuvieron que ser internados en salas de urgencias, la mayoría con ayuda de ventiladores.

El total de fallecimientos se acerca al de pacientes que han requerido cuidados intensivos para enfrentar el contagio.

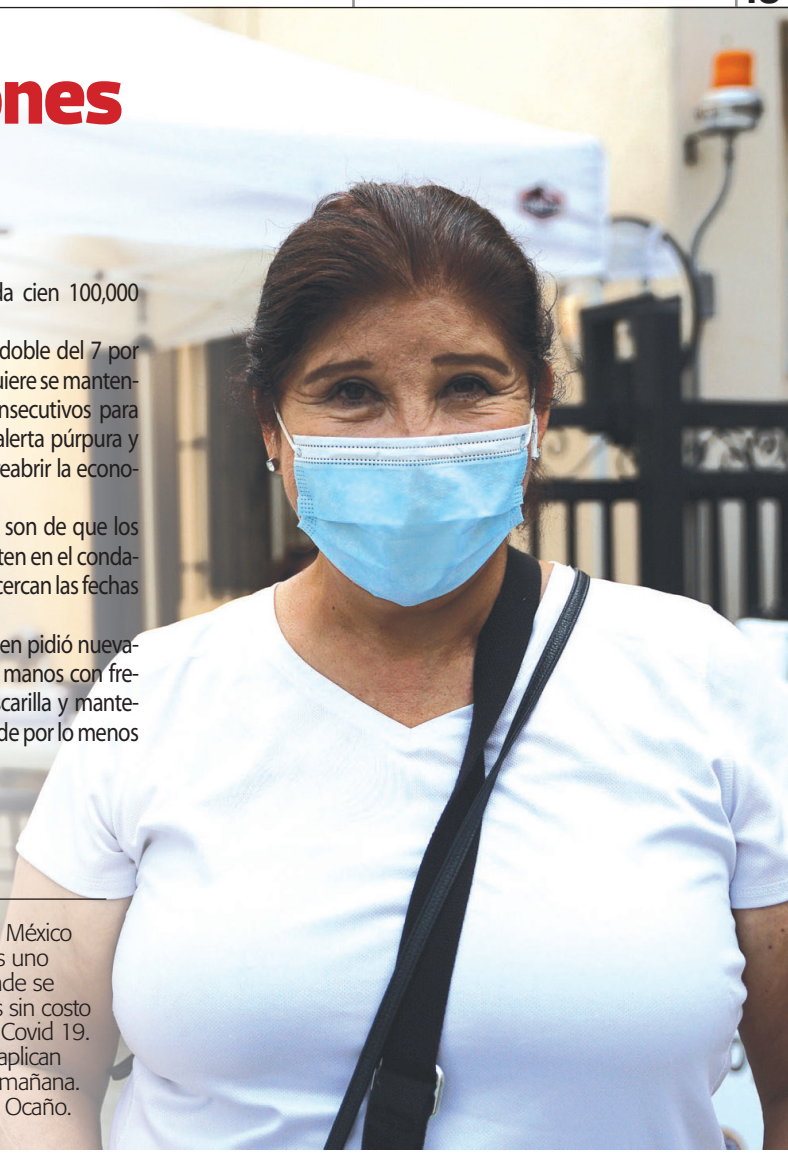
La tasa de contagios esta semana ronda en 15.6 casos confirmados por cada cien 100,000 residentes.

Esto es más del doble del 7 por ciento que se requiere se mantenga varios días consecutivos para salir del nivel de alerta púrpura y volver a intentar reabrir la economía.

Las perspectivas son de que los contagios aumenten en el condado conforme se acercan las fechas decembrinas.

La doctora Wooten pidió nuevamente lavarse las manos con frecuencia, usar mascarilla y mantener una distancia de por lo menos seis pies.

Manuel Ocaño



El consulado de México en San Diego es uno de los sitios donde se ofrecen pruebas sin costo para detectar el Covid 19. Las pruebas se aplican los lunes por la mañana. Foto de Manuel Ocaño.



SESIÓN COMUNITARIA PARA FAMILIAS Y JÓVENES

Padres, guardianes y jóvenes de 12 años o más, ¡únanse con nosotros para compartir sus experiencias y sus ideas!

Sesión virtual para escuchar a la comunidad
12 de diciembre de 2020
11:00 am a 12:30 pm

Les invitamos a que participen en una plática sobre los impactos de la pandemia y los más recientes eventos en la salud del comportamiento.
Los jóvenes pueden obtener dos horas de servicio comunitario por asistir.

Visite www.ListenToSanDiego.org para obtener más información y para registrarse.

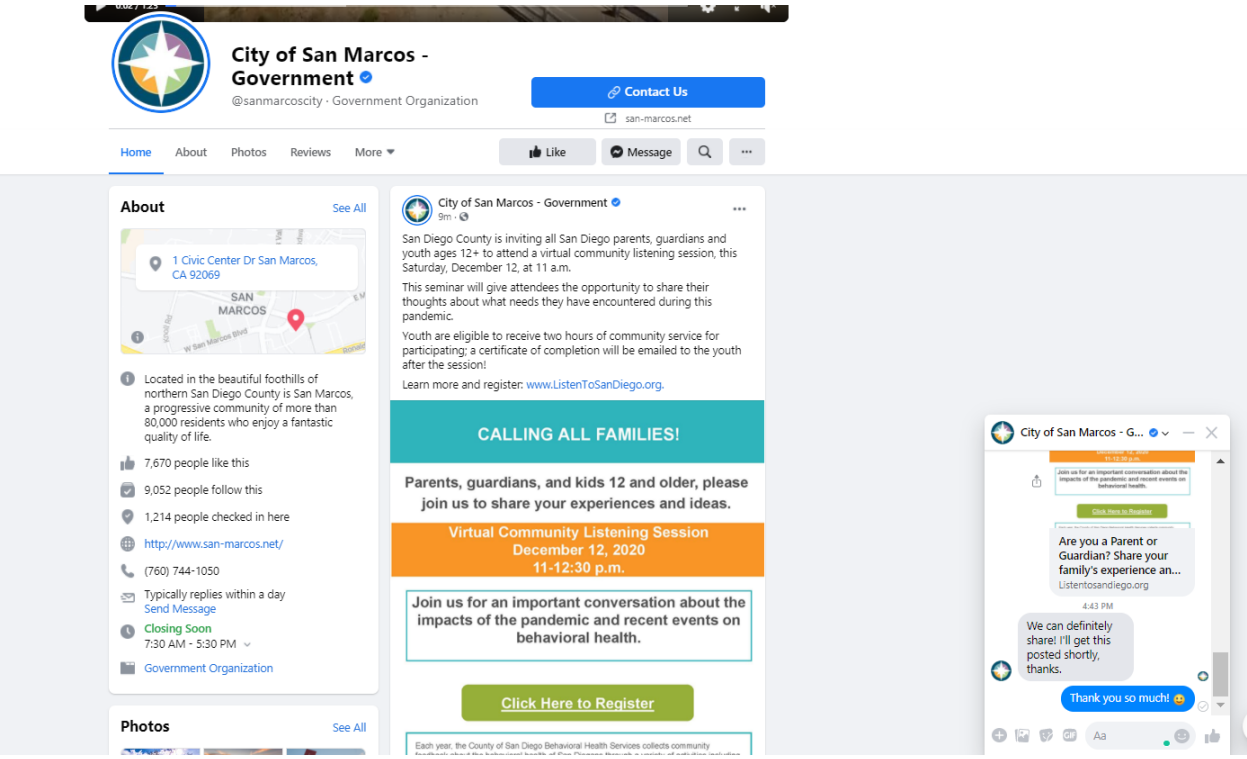
Cada año, los servicios de salud de conducta del condado de San Diego recopilan comentarios sobre la salud de conducta de los habitantes de San Diego a través de una variedad de actividades que incluyen sesiones de escucha de la comunidad pública, grupos de enfoque y entrevistas. Los comentarios se utilizan para informar la planificación del programa, y los resultados se publican anualmente en el programa de tres años de la Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés) y el plan de gastos y las actualizaciones anuales.

LIVE WELL SAN DIEGO | COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

To learn more and to register visit listentosandiego.org

SAN DIEGO STATE UNIVERSITY
Institute for Public Health

Appendix 5: Social Media and Community Calendar Posts



Live Well San Diego | Learn More | Liked | Message

the County of San Diego's vision for a region that is Building Better Health, Living Safely and Thriving.

Although Live Well San Diego began in 2010 as a health strategy, it has evolved into a greater vision to improve the health, safety and well-being of ... See More

3,618 people like this including 2 of your friends

4,265 people follow this

http://www.livewellsd.org/

Send Message

Government Organization

Photos

See All



Videos

See All



Register today for the #LiveWellAdvance...

Live Well San Diego
December 1, 2020 ·

Break the Stigma around mental health and let the County of San Diego hear your voices! How has COVID or recent events impacted your mental health?

Don't miss out on this Virtual Community Listening Session on December 12th from 11-12pm.

If you would like to share input regarding mental health and/or substance use disorder services, please visit www.ListentoSanDiego.org to register. Once registered, a link will be sent with the virtual meeting information. #LiveWellSD



Breaking Down Barriers
November 24, 2020 ·

Break the Stigma around mental health and let the County of San Diego hear our voices! How has COVID or recent events impacted

PANDEMIC LISTENING SESSION FROM SDSU



The COVID-19 pandemic has hit San Diego families hard, and the County of San Diego wants to hear from families and youth about what they need during this tough time. We would love your help in spreading the word to all families and youth at Olympian High about this opportunity for their voices to be heard.

All San Diego parents/guardians and all youth ages 12 and older are invited to attend a virtual community listening session, hosted by the SDSU Institute for Public Health, on **Saturday, December 12, 2020, at 11 a.m**. to share their thoughts. Families and youth can register here: https://sdsu.co1.qualtrics.com/ife/form/SV_emlRIMZXpbTwFLv

A Zoom link and instructions will be sent to the week of the listening session.

Youth are eligible to receive two hours of community service hours for participating; a certificate of completion will be emailed to the youth after the session!

The session will focus on how the pandemic has impacted the well-being of San Diego families:

What are the most serious mental health issues facing our families during this time?

What about concerns related to substance use?

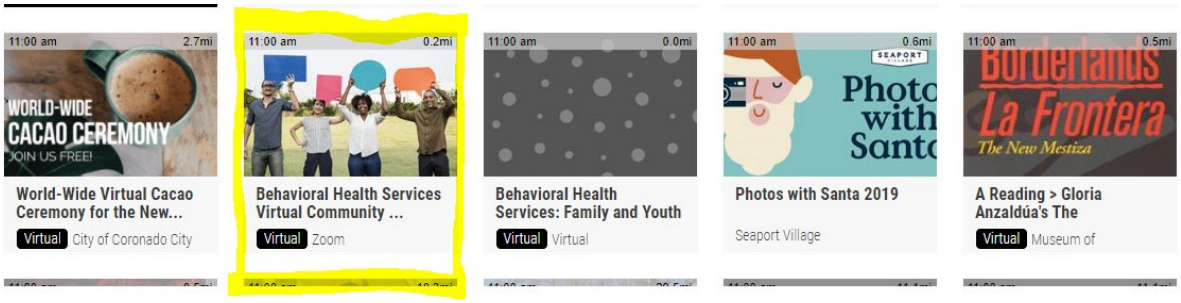
How can we make sure that youth and families come out of this crisis stronger than ever?

For questions, or if you would prefer to participate in a one-on-one interview rather than in the group event, please visit our website, http://listentosandiego.org/ , or feel free to contact the following IPH staff:

Martha Crowe: mcrowe@sdsu.edu 619-559-1851

Nasreen Nabizadeh: nnabizadeh@sdsu.edu 619-890-7972

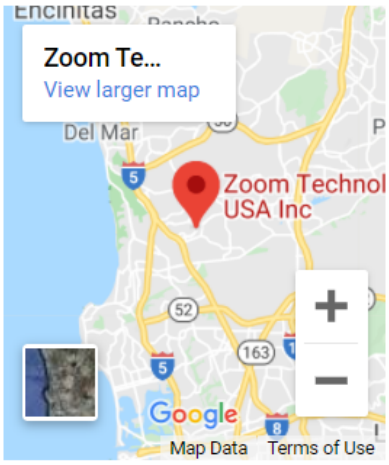
Click here for listening session flyer Oprima aquí para ver información español





Behavioral Health Services Virtual Community Listening Session

Saturday, December 12, 2020
11:00 am - 12:30 pm



Zoom

San Diego, CA

Virtual Event URL: http://listentosandiego.org/

Price: Free

Note: Virtual Event.

Dear San Diego Community Member,

We need your help! The COVID-19 pandemic has hit San Diego families hard, and the County of San Diego wants to hear from families and youth about what they need during this tough time.

All San Diego parents/guardians and all youth ages 12 and older are invited to attend a virtual community listening session, hosted by the SDSU Institute for Public Health, on Saturday, December 12, 2020 at 11 a.m. to share their thoughts. Please register here: https://sdsu.co1.qualtrics.com/jfe/form/SV_emlRlMZXpbTwFLv

Please note that each member of the family who attends will need to

Show Full Description



Behavioral Health Services Virtual Community Listening Session

Virtual

Saturday, December 12, 2020 at 11 a.m.

Free



Above: Promotional photo for Behavioral Health Services Virtual Community Listening Session. Courtesy of Listen to San Diego.

Facebook Twitter Email Reminder

Categories

Family, Kids, Teens, Health & Wellness, Lectures & Classes, Virtual

Behavioral Health Services Virtual Community Listening Session

WHEN Saturday, December 12, 2020 at 11 a.m.
WHERE Virtual
Map
AGES 12+
COST Free

Parents, caregivers, and youth 12 and older, please join us to share your experiences and ideas with Behavioral Health Services Virtual Community Listening Session!

Join us for an important conversation about the impacts of the pandemic and recent events on behavioral health.

Youth can earn two hours of community service for attending.

Dates and times of events are subject to change without notice. Always check the event organizer's website for the most updated schedule before attending. Check local COVID-19 ***restrictions and updates****.*

Local Event

DEC
12

Behavioral Health Services Virtual Community Listening Session

Saturday, 11:00 am San Diego, CA



Interested Reply Share

Event Details

Like 0 Share

Sat, Dec 12, 2020 at 11:00 AM Add to calendar

Zoom Virtual Meeting

Parents, caregivers, and youth 12 and older, please join us to share your experiences and ideas!

Behavioral Health Services: Virtual Community Listening Session

When: December 12, 2020

Time: 11am to 12:30pm

Join us for an important conversation about the impacts of the pandemic and recent events on behavioral health.

Youth can earn two hours of community service for attending.

Visit www.ListenToSanDiego.org for more details and to register

211 SAN DIEGO

ıd a community event near you!

ıay take up to 5 business days after submission for a calendar event to be add

ımmunity Events Calendar

ıay Saturday, December 12 Print Week Month Agenda

10:30am Alzheimer's San Diego-Central San Diego Saturday Morning Group.

11:00am **Behavioral Health Services: Family and Youth Community Listening Session**

When Sat, December 12, 11:00am – 12:30pm

Where Virtual (map)

Description

The COVID-19 pandemic has been hard on many San Diego families. The County of San Diego Behavioral Health Services wants to hear from families and youth about the pandemic has affected your family's behavioral health during this challenging time.

San Diego County parents/guardians and youth ages 12 and older are invited to attend a virtual community listening session, hosted by the SDSU Institute for Public Health, on **Saturday, December 12, 2020 at 11 a.m.** to share their thoughts. Please register here: listentosandiego.org. *Please note that each member of the family who attends will need to complete a separate registration.* A Zoom link and instructions will be sent to the week of the listening session.

Youth are eligible to receive two hours of community service hours that can be used to meet school requirements for participating; a certificate of completion will be emailed to the youth after the session!

The session will focus on how the pandemic has impacted the behavioral health well-being of San Diego families throughout San Diego Counties:

- What are the most serious mental health issues facing our families during this time?

and instructions will be sent to the week of the listening session.

Youth are eligible to receive two hours of community service hours that can be used to meet school requirements for participating; a certificate of completion will be emailed to the youth after the session!

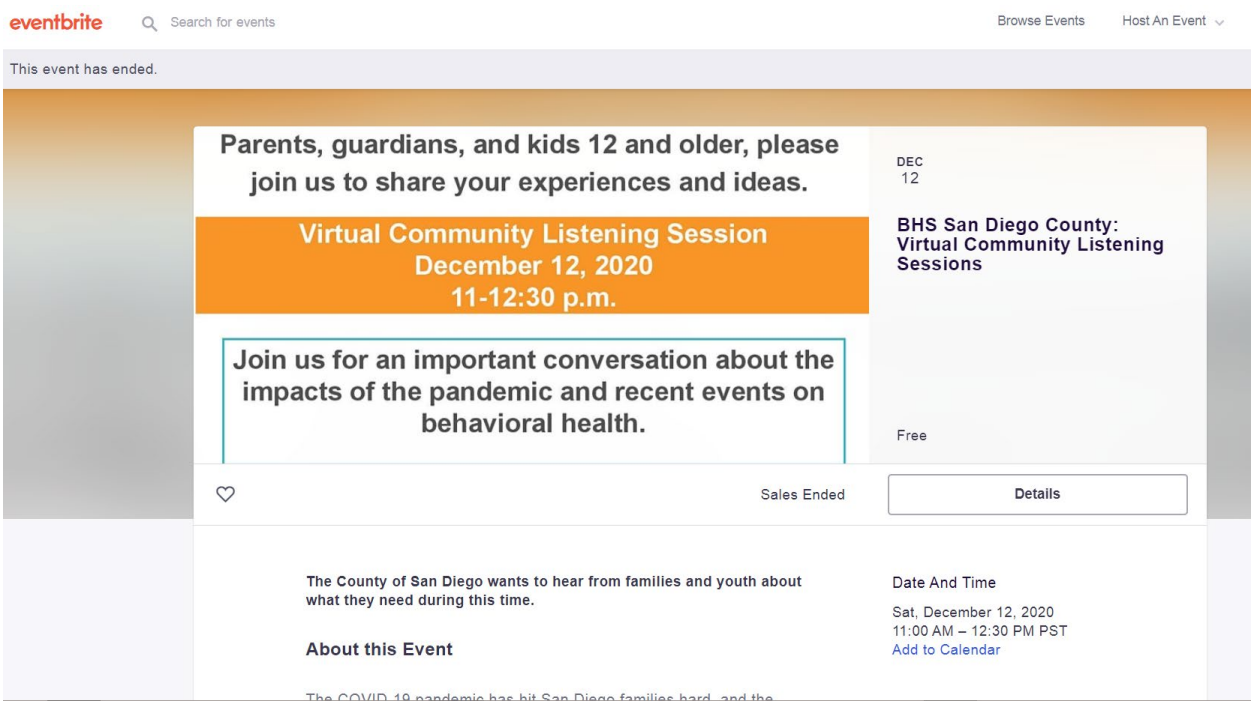
The session will focus on how the pandemic has impacted the behavioral health well-being of San Diego families throughout San Diego Counties:

- What are the most serious mental health issues facing our families during this time?
- What are the most serious substance use challenges facing our families during this time?
- How can we make sure that youth and families come out of this crisis stronger than ever?

For questions, or if you would prefer to participate in a one-on-one interview rather than a group event, please feel free to contact me at mcrowe@sdsu.edu.

With warm wishes for your health and safety,

Martha Crowe
Research Associate
Adjunct Assistant Professor
Institute for Public Health
School of Public Health
San Diego State University


eventbrite
Search for events
Browse Events
Host An Event
This event has ended.
Parents, guardians, and kids 12 and older, please join us to share your experiences and ideas.
Virtual Community Listening Session
December 12, 2020
11-12:30 p.m.
Join us for an important conversation about the impacts of the pandemic and recent events on behavioral health.
DEC
12
BHS San Diego County: Virtual Community Listening Sessions
Free
Sales Ended
Details
The County of San Diego wants to hear from families and youth about what they need during this time.
About this Event
Date And Time
Sat, December 12, 2020
11:00 AM – 12:30 PM PST
Add to Calendar

< Previous Month

December 2020

Next Month >

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
29	30	1 5:00 PM City Council Meeting	2 4:00 PM Cancelled - Historic Preservation Commission 6:00 PM SAFETY COMMISSION-CANCELLED	3 6:00 PM Regular Meeting of the Growth Management Oversight Commission	4	5
6 2:00 PM Virtual Compost Workshop	7	8 5:00 PM City Council Meeting	9 Planning Commission Meeting 11:00 AM Virtual Storytime 6:00 PM Charter Review Commission	10	11 6:30 AM Public Works Offices Closed	12 11:00 AM Behavioral Health Services: Family and Youth Community Listening Session
13	14 5:15 PM Board of Appeals & Advisors	15 5:00 PM City Council Meeting	16 11:00 AM Virtual Storytime 4:00 PM	17 6:00 PM Regular Meeting of the Growth Management Oversight Commission	18	19

Font Size: Share & Bookmark Feedback Print

Behavioral Health Services: Family and Youth Community Listening Session

Date: 12/12/2020 11:00 AM - 12:30 PM

Location: Virtual Zoom Meeting
6505 Alvarado Road
San Diego, California 92120

Submission Attachment: Behavioral Health Services: Family and Youth Community Listening Session.docx

Add to my Calendar

Dear San Diego Community Member,
We need your help! The COVID-19 pandemic has hit San Diego families hard, and the County of San Diego wants to hear from families and youth about what they need during this tough time.

All San Diego parents/guardians and all youth ages 12 and older are invited to attend a virtual community listening session, hosted by the SDSU Institute for Public Health, on Saturday, December 12, 2020 at 11 a.m. to share their thoughts. Please register here: https://sdsu.co1.qualtrics.com/jfe/form/SV_emIRIMZXpbTwFLv
Please note that each member of the family who attends will need to complete a separate registration. A Zoom link and instructions will be sent to the week of the listening session.

Youth are eligible to receive two hours of community service hours for participating; a certificate of completion will be emailed to the youth after the session!

The session will focus on how the pandemic has impacted the well-being of San Diego families:
What are the most serious mental health issues facing our families during this time?
What about concerns related to substance use? How can we make sure that youth and families come out of this crisis stronger than ever?

For questions, or if you would prefer to participate in a one-on-one interview rather than in the group event, please visit our website, http://listentosandiego.org/ , or feel free to contact the following IPH staff:

Martha Crowe: mcrowe@sdsu.edu 619-559-1851
Nasreen Nabizadeh: nnabizadeh@sdsu.edu 619-890-7972

Return to full list >>

Appendix 6: Email Marketing Content

Recruitment/Promotion/Marketing Email Content

FAMILY/YOUTH FORUM EMAIL

Subject Line: How do we keep our families and kids strong?

Dear San Diego Community Member,
We need your help! The COVID-19 pandemic has hit San Diego families hard, and the County of San Diego wants to hear from families and youth about what they need during this tough time.

All San Diego parents/guardians and all youth ages 12 and older are invited to attend a virtual community listening session, hosted by the SDSU Institute for Public Health, on Saturday, December 12, 2020 at 11 a.m. to share their thoughts. Please register here: https://sdsu.co1.qualtrics.com/jfe/form/SV_emlRlMZXpbTwFLv
Please note that each member of the family who attends will need to complete a separate registration. A Zoom link and instructions will be sent to the week of the listening session.

Youth are eligible to receive two hours of community service hours for participating; a certificate of completion will be emailed to the youth after the session!

The session will focus on how the pandemic has impacted the well-being of San Diego families:
What are the most serious mental health issues facing our families during this time?
What about concerns related to substance use? How can we make sure that youth and families come out of this crisis stronger than ever?

For questions, or if you would prefer to participate in a one-on-one interview rather than in the group event, please visit our website, http://listentosandiego.org/ , or feel free to contact the following IPH staff:

Martha Crowe: mcrowe@sdsu.edu 619-559-1851

With warm wishes for your health and safety,

YOUR NAME

This virtual listening session is a collaborative effort between the Institute for Public Health at SDSU and the San Diego County Health and Human Services Agency, Behavioral Health Services (BHS).

PROVIDER FORUM EMAIL

Subject Line: SD County Forum: How are you and the people you serve?

To Whom It May Concern Or Dear _____,

I'd like to invite you and your colleagues to attend an upcoming virtual Community Listening Session for providers of behavioral health services on **Tuesday, December 1, 2020 at 10am.** This virtual session is being facilitated by the Institute for Public Health at SDSU in collaboration with County of San Diego Behavioral Health Services (BHS).

Each year, BHS collects stakeholder input about the behavioral health needs of San Diegans through a variety of activities. This year, planned engagement activities include public listening sessions, focus groups, and interviews. Input is used to inform program planning, and results are included in the MHSA Three-Year Program and Expenditure Plan and Annual Updates.

Our goal this year is to understand how recent events, including the pandemic, have affected the behavioral health of the people you serve and how BHS can help promote resiliency in our community.

All mental health and substance use disorder service providers working in San Diego County are invited to participate. Please register here:
https://sdsu.co1.qualtrics.com/jfe/form/SV_emlRlMZXpbTwFLv
Please note that for security and privacy reasons, a Zoom link will be not sent out until a few days before the session.

For questions, or if you would prefer to participate in a one-on-one interview rather than in the group event, please visit our website, http://listentosandiego.org/ , or feel free to contact the following IPH staff:

Martha Crowe: mcrowe@sdsu.edu 619-559-1851

With warm wishes for your health and safety,

YOUR NAME

This virtual listening session is a collaborative effort between the Institute for Public Health at SDSU and the San Diego County Health and Human Services Agency, Behavioral Health Services (BHS).

PREVIOUS FORUM ATTENDEES EMAIL

Subject: We'd like to hear from you again this year!

Dear _____,

I hope this email finds you safe and well. Last year you registered to attend one or more Community Forums conducted by the Institute for Public Health on behalf of the County of San Diego Behavioral Health Services (BHS). We'd like to invite you to attend a *Community Listening Session* again this year.

Each year, BHS collects community input about the behavioral health of San Diegans through a variety of activities including public listening sessions, focus groups, and interviews. This information is used to inform future behavioral health services program planning, and results are published annually in the MHSA Three-Year Program and Expenditure Plan and Annual Updates.

Our goal this year is to understand how recent events, including the pandemic, have affected San Diego county residents' behavioral health and how BHS can help promote resiliency in our community. Your input will be used to inform behavioral health services program planning.

Two community listening sessions will be hosted this year.

If you are a **behavioral health service provider**, we invite you to attend a session specifically for those who offer mental health and substance use disorder services on **December 1, 2020 at 10 a.m.** All providers working in San Diego County are invited to attend.

If you are a community member concerned about the behavioral health and well-being of San Diego County youth and families, we invite you to attend our community listening session on **Saturday, December 12, 2020 at 11a.m.** Parents, caregivers, and youth 12 years and older are welcome!

To register for a community listening session, please visit: <<INSERT LINK>>. Please note that for security and privacy reasons, a Zoom link will be not sent out until a few days before the session.

For questions, or if you would prefer to participate in a one-on-one interview rather than a group event, please feel free to contact me at mcrowe@sdsu.edu or 619-559-1851.

With warm wishes for your health and safety,

YOUR NAME

This virtual listening session is a collaborative effort between the Institute for Public Health at SDSU and the San Diego County Health and Human Services Agency, Behavioral Health Services (BHS).

Dear Parent/Guardian,

Greetings! We hope this email finds you and your family safe and well.

We wanted to let you know that your child has signed up to attend a virtual community listening session hosted by the Institute for Public Health at SDSU on December 12 , 2020, at 11 a.m. and indicated that you have given your permission for attendance.

This session is part of the San Diego County Behavioral Health Services' annual community engagement effort. Feedback will be used to create, modify, and expand behavioral health programs for San Diego residents.

The session will focus on how the pandemic has impacted the well-being of San Diego families and youth:

- What are the most serious mental health issues facing youth and families during this time?
- What about concerns related to substance use?
- How can we make sure that youth and families come out of this crisis stronger than ever?

We would love for you to attend as well! All San Diego parents/guardians and all youth ages 12 and older are invited to share their thoughts. Please register here:_____.

Please note that each member of the family who attends will need to complete a separate registration.

Youth are eligible to receive two hours of community service hours for participating; a certificate of completion will be emailed to the youth after the session!

A Zoom link and instructions will be sent to you the week of the listening session.

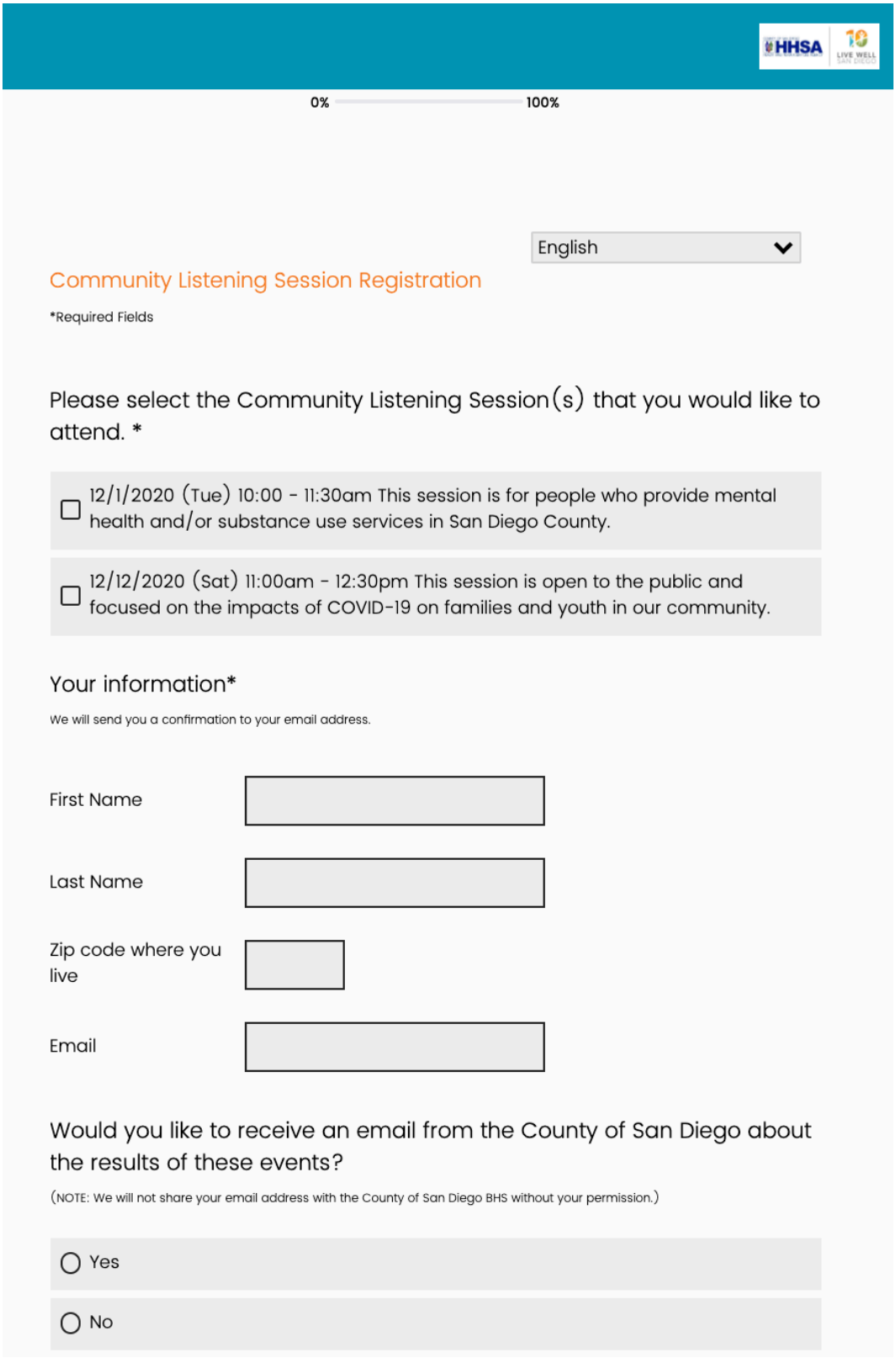
Please feel free to contact me if you have questions or if you would like to participate in a one-on-one interview about these issues: mcrowe@sdsu.edu. You can also learn more by visiting listentosandiego.org.

With warm wishes for your health and safety,

Martha Crowe
Research Associate
Institute for Public Health
San Diego State University
School of Public Health

Appendix 7: Online Registration Form/Demographics Survey

Community Listening Session Registration Form



0% 100%

English

Community Listening Session Registration

*Required Fields

Please select the Community Listening Session(s) that you would like to attend. *

- ☐ 12/1/2020 (Tue) 10:00 - 11:30am This session is for people who provide mental health and/or substance use services in San Diego County.
- ☐ 12/12/2020 (Sat) 11:00am - 12:30pm This session is open to the public and focused on the impacts of COVID-19 on families and youth in our community.

Your information*

We will send you a confirmation to your email address.

First Name

Last Name

Zip code where you live

Email

Would you like to receive an email from the County of San Diego about the results of these events?

(NOTE: We will not share your email address with the County of San Diego BHS without your permission.)

- ○ Yes
- ○ No

Do you require a language translation service at the event? *

- ○ **No**
- ○ American Sign Language
- ○ Arabic
- ○ Farsi
- ○ Spanish
- ○ Tagalog
- ○ Vietnamese

Which community groups do you represent? (Select all that apply)

- ☐ Community Member
- ☐ Consumer/Client
- ☐ Family Member of Consumer
- ☐ Law Enforcement
- ☐ School Personnel (please provide your school name and title)

[ ]

- ☐ Provider (please provide your organization name and title)

[ ]

- ☐ Immigrant
- ☐ Refugee/Newcomer
- ☐ Asylee
- ☐ Veterans/Military
- ☐ Homeless
- ☐ African
- ☐ Chaldean
- ☐ LGBTQI
- ☐ None of the above

What is your age group? *

- ○ age 0-11 years old
- ○ age 12-15 years old
- ○ age 16-17 years old
- ○ age 18-25 years old
- ○ age 26-59 years old
- ○ age 60 years old or over
- ○ Prefer not to answer

The following demographic data collected on this form will be used strictly to generate summary reports about community engagement events held by County of San Diego HHSA Behavioral Health services.

What is your race?

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Other (please specify)

[ ]

- ☐ Prefer not to answer

Are you of any following origin?

- [ ] Hispanic or Latino:
- [ ] Caribbean
- [ ] Central American
- [ ] Mexican/Mexican-American/Chicano
- [ ] Puerto Rican
- [ ] South American
- [ ] Hispanic-Other (please specify)

- [ ] Non-Hispanic or Non-Latino:
- [ ] African
- [ ] Asian Indian/South Asian
- [ ] Cambodian
- [ ] Chinese
- [ ] Eastern European
- [ ] European
- [ ] Filipino
- [ ] Japanese
- [ ] Korean
- [ ] Vietnamese
- [ ] Middle Eastern
- [ ] Non-Hispanic Other (please specify)

- [ ] Prefer not to answer

What is the primary language you speak or use at home?

- ◯ English
- ◯ Arabic
- ◯ Farsi
- ◯ Spanish
- ◯ Tagalog
- ◯ Vietnamese
- ◯ Other (please specify)

What best describes your sexual orientation?

- ◯ Gay or Lesbian
- ◯ Heterosexual or Straight
- ◯ Bisexual
- ◯ Questioning or unsure of sexual orientation
- ◯ Queer
- ◯ Another sexual orientation (please specify)
- ◯ Prefer not to answer

Do you have a disability, defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

Are you a veteran?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

What was your assigned sex at birth?

- ◯ Male
- ◯ Female
- ◯ Other (please specify)

[ ]

- ◯ Prefer not to answer

Please mark the gender identity that best describes you currently.

- ◯ Male
- ◯ Female
- ◯ Transgender
- ◯ Genderqueer
- ◯ Questioning or unsure of gender identity
- ◯ Another gender identity (please specify)

[ ]

- ◯ Prefer not to answer

← Submit

English
✓ Español (América Latina)
Farsi
Tagalog
Tiếng Việt
العربية

Inscripción para sesiones de escucha comunitaria

*Respuesta requerida

Seleccione las sesiones de escucha comunitaria a las que le gustaría asistir. *

- ☐ 12/1/2020 (martes) 10:00 - 11:30am. Esta sesión es para personas que brindan servicios de salud mental y / o consumo de sustancias en el Condado de San Diego.
- ☐ 12/12/2020 (sábado) 11:00am - 12:30pm. Esta sesión está abierta al público y se enfoca en los impactos de COVID-19 en las familias y los jóvenes de nuestra comunidad.

Su información *
Enviaremos una confirmación a su dirección de correo electrónico.

Nombre (p.ej., Julia)

Apellido (p.ej., García)

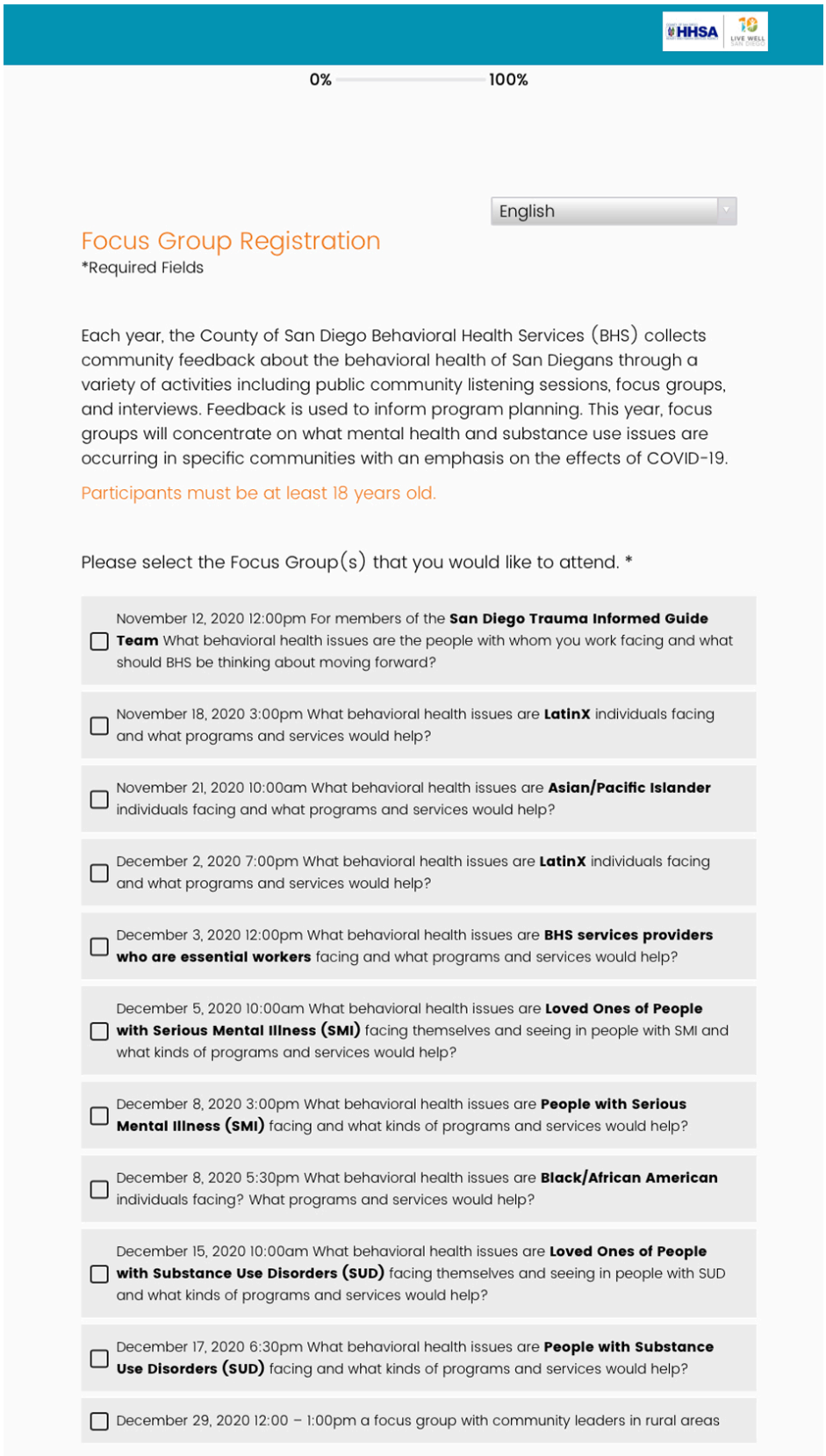
Código postal donde vives

Correo electrónico

¿Le gustaría recibir un correo electrónico del Condado de San Diego sobre los resultados de estos eventos? *

TENGA EN CUENTA: No compartiremos su dirección de correo electrónico con el BHS del Condado de San Diego sin su permiso.

Focus Group Registration Form



Your information*

We will send you a confirmation to your email address.

First Name

Last Name

Zip code where you live

Email

Would you like to receive an email from the County of San Diego about the results of these events?

(NOTE: We will not share your email address with the County of San Diego BHS without your permission.)

- ◯ Yes
- ◯ No

Do you require a language translation service at the event? *

- ◯ **No**
- ◯ American Sign Language
- ◯ Arabic
- ◯ Farsi
- ◯ Spanish
- ◯ Tagalog
- ◯ Vietnamese

Which community groups do you represent? (Select all that apply)

- [ ] Community Member
- [ ] Consumer/Client
- [ ] Family Member of Consumer
- [ ] Law Enforcement
- [ ] School Personnel (please provide your school name and title)
- [ ] Provider (please provide your organization name and title)
- [ ] Immigrant
- [ ] Refugee/Newcomer
- [ ] Asylee
- [ ] Veterans/Military
- [ ] Homeless
- [ ] African
- [ ] Chaldean
- [ ] LGBTQI
- [ ] None of the above

What is your age group? *

- ○ age 0-11 years old
- ○ age 12-15 years old
- ○ age 16-17 years old
- ○ age 18-25 years old
- ○ age 26-59 years old
- ○ age 60 years old or over
- ○ Prefer not to answer

Are you of any following origin?

- [ ] Hispanic or Latino:
- [ ] Caribbean
- [ ] Central American
- [ ] Mexican/Mexican-American/Chicano
- [ ] Puerto Rican
- [ ] South American
- [ ] Hispanic-Other (please specify)

- [ ] Non-Hispanic or Non-Latino:
- [ ] African
- [ ] Asian Indian/South Asian
- [ ] Cambodian
- [ ] Chinese
- [ ] Eastern European
- [ ] European
- [ ] Filipino
- [ ] Japanese
- [ ] Korean
- [ ] Vietnamese
- [ ] Middle Eastern
- [ ] Non-Hispanic Other (please specify)

- [ ] Prefer not to answer

What is the primary language you speak or use at home?

- ◯ English
- ◯ Arabic
- ◯ Farsi
- ◯ Spanish
- ◯ Tagalog
- ◯ Vietnamese
- ◯ Other (please specify)

What best describes your sexual orientation?

- ◯ Gay or Lesbian
- ◯ Heterosexual or Straight
- ◯ Bisexual
- ◯ Questioning or unsure of sexual orientation
- ◯ Queer
- ◯ Another sexual orientation (please specify)
- ◯ Prefer not to answer

Do you have a disability, defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

Are you a veteran?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

What was your assigned sex at birth?

- ◯ Male
- ◯ Female
- ◯ Other (please specify)

[ ]

- ◯ Prefer not to answer

Please mark the gender identity that best describes you currently.

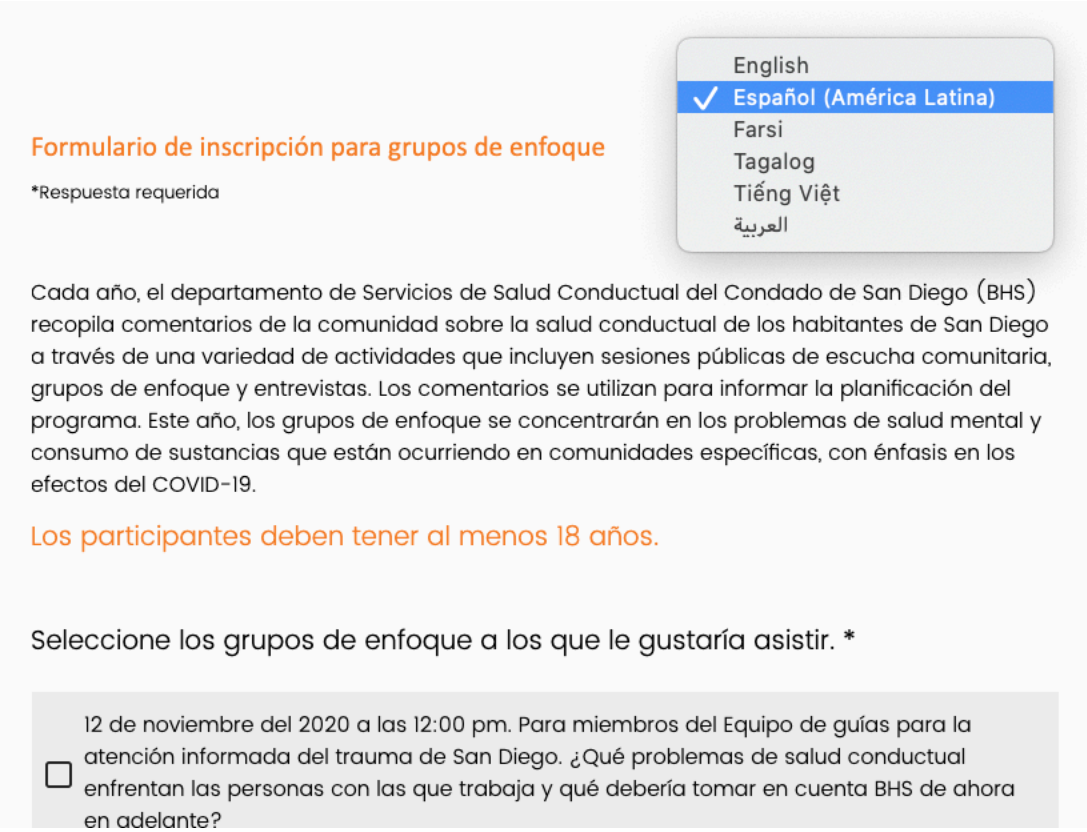
- ◯ Male
- ◯ Female
- ◯ Transgender
- ◯ Genderqueer
- ◯ Questioning or unsure of gender identity
- ◯ Another gender identity (please specify)

[ ]

- ◯ Prefer not to answer

← Submit

Spanish:


English
Español (América Latina)
Farsi
Tagalog
Tiếng Việt
العربية
Formulario de inscripción para grupos de enfoque
*Respuesta requerida
Cada año, el departamento de Servicios de Salud Conductual del Condado de San Diego (BHS) recopila comentarios de la comunidad sobre la salud conductual de los habitantes de San Diego a través de una variedad de actividades que incluyen sesiones públicas de escucha comunitaria, grupos de enfoque y entrevistas. Los comentarios se utilizan para informar la planificación del programa. Este año, los grupos de enfoque se concentrarán en los problemas de salud mental y consumo de sustancias que están ocurriendo en comunidades específicas, con énfasis en los efectos del COVID-19.
Los participantes deben tener al menos 18 años.
Seleccione los grupos de enfoque a los que le gustaría asistir. *
12 de noviembre del 2020 a las 12:00 pm. Para miembros del Equipo de guías para la atención informada del trauma de San Diego. ¿Qué problemas de salud conductual enfrentan las personas con las que trabaja y qué debería tomar en cuenta BHS de ahora en adelante?

English

Focus Group Satisfaction Survey

Thank you for joining the Focus Group on .

Overall, how satisfied were you with this Focus Group?

- ◯ Very Satisfied
- ◯ Satisfied
- ◯ Somewhat Satisfied
- ◯ Not at all Satisfied

How convenient was the use of a virtual platform for this meeting?

- ◯ Very Convenient
- ◯ Convenient
- ◯ Somewhat Convenient
- ◯ Not at all Convenient

The day of week of this Focus Group was a good fit for my schedule.

- ◯ Agree
- ◯ Somewhat Agree
- ◯ Somewhat Disagree
- ◯ Disagree

The time of day of this Focus Group was a good fit for my schedule.

- ◯ Agree
- ◯ Somewhat Agree
- ◯ Somewhat Disagree
- ◯ Disagree

The topics covered at today's Focus Group were useful.

- ◯ Agree
- ◯ Somewhat Agree
- ◯ Somewhat Disagree
- ◯ Disagree

How did you learn of this Focus Group?

- ☐ Flyer
- ☐ Friend/Colleague/Family Member
- ☐ Email from:

[ ]

- ☐ Newspaper Ad
- ☐ Social Media
- ☐ Other:

[ ]

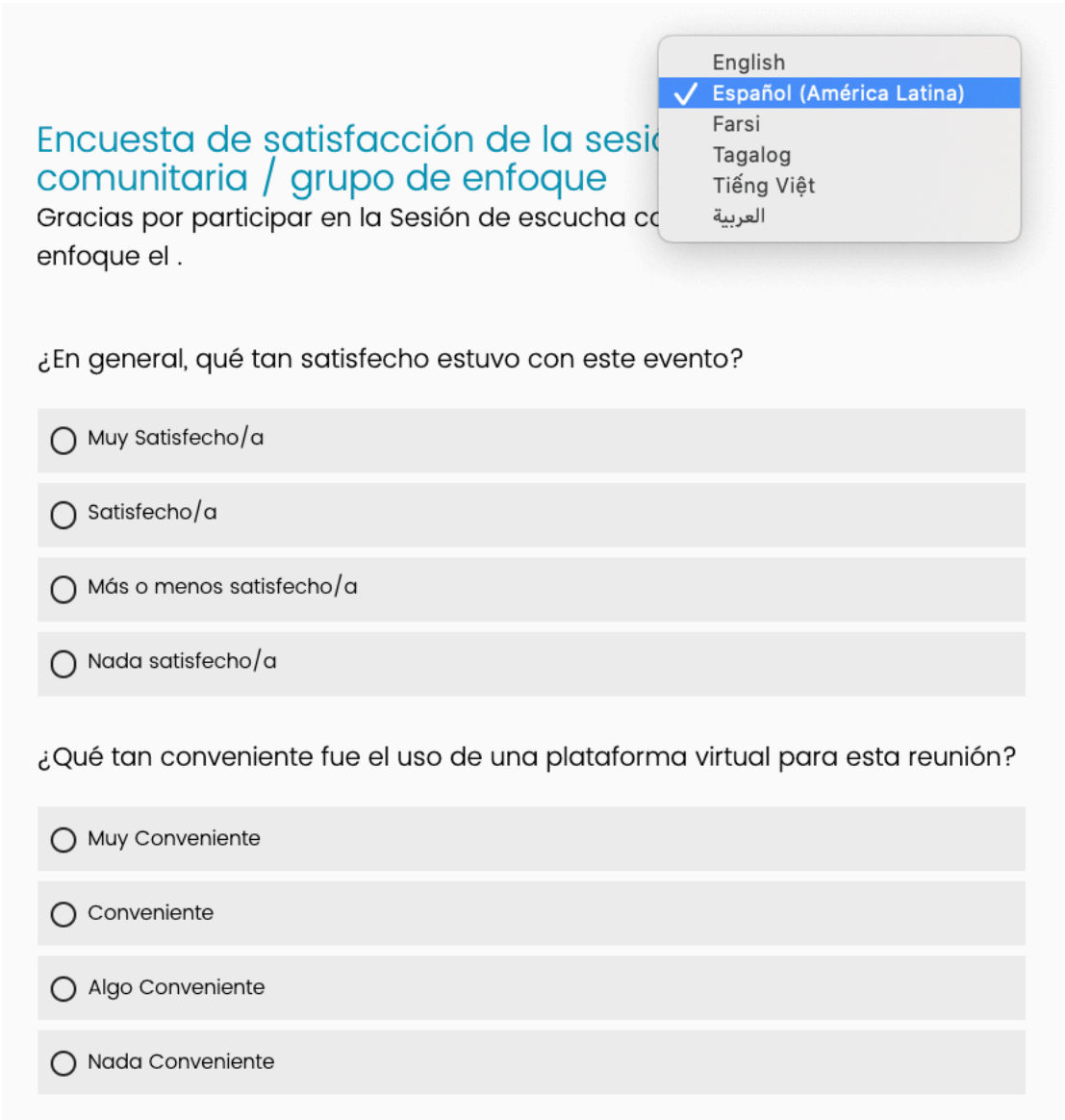
Do you have suggestions for how these Focus Groups could be improved?

[ ]

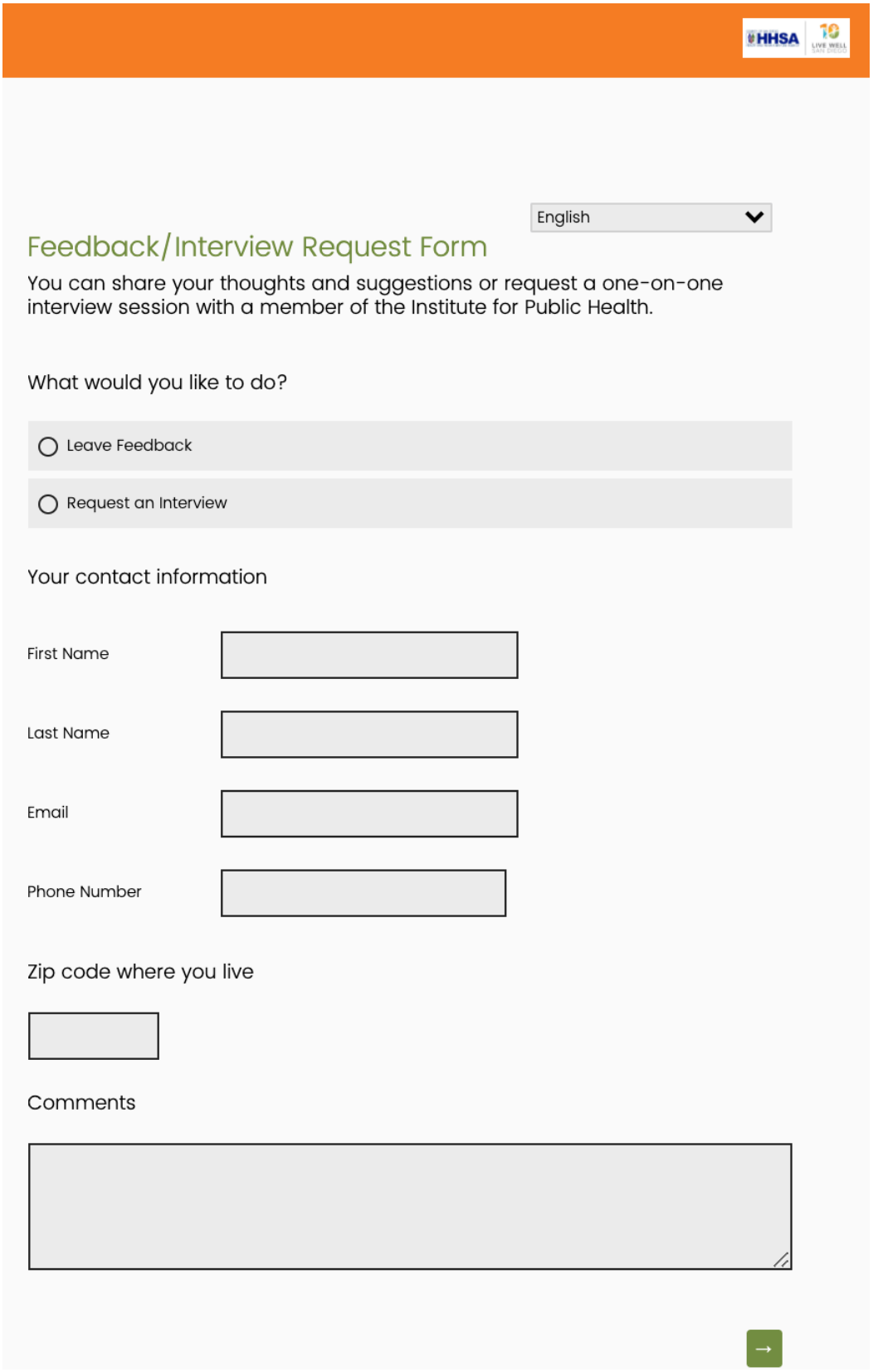
Do you have any other comments to share with us?

[ ]

In Spanish


English
Español (América Latina)
Farsi
Tagalog
Tiếng Việt
العربية
Encuesta de satisfacción de la sesi
comunitaria / grupo de enfoque
Gracias por participar en la Sesión de escucha co
enfoque el .
¿En general, qué tan satisfecho estuvo con este evento?
Muy Satisfecho/a
Satisfecho/a
Más o menos satisfecho/a
Nada satisfecho/a
¿Qué tan conveniente fue el uso de una plataforma virtual para esta reunión?
Muy Conveniente
Conveniente
Algo Conveniente
Nada Conveniente

Feedback/Interview Request From



The following demographic data collected on this form will be used strictly to generate summary reports about community engagement events held by County of San Diego HHSA Behavioral Health services.

Which community groups do you represent? (Select all that apply)

- [ ] Community Member
- [ ] Consumer/Client
- [ ] Family Member of Consumer
- [ ] Law Enforcement
- [ ] School Personnel (please provide your school name and title)

- [ ] Provider (please provide your organization name and title)

- [ ] Immigrant
- [ ] Refugee/Newcomer
- [ ] Asylee
- [ ] Veterans/Military
- [ ] Homeless
- [ ] African
- [ ] Chaldean
- [ ] LGBTQI
- [ ] None of the above

What is your age group?

- ◯ age 0-11 years old
- ◯ age 12-15 years old
- ◯ age 16-17 years old
- ◯ age 18-25 years old
- ◯ age 26-59 years old
- ◯ age 60 years old or over
- ◯ Prefer not to answer

What is your race?

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Other (please specify)

[ ]

- ☐ Prefer not to answer

Are you of any following origin?

- [ ] Hispanic or Latino:
- [ ] Caribbean
- [ ] Central American
- [ ] Mexican/Mexican-American/Chicano
- [ ] Puerto Rican
- [ ] South American
- [ ] Hispanic-Other (please specify)

- [ ] Non-Hispanic or Non-Latino:
- [ ] African
- [ ] Asian Indian/South Asian
- [ ] Cambodian
- [ ] Chinese
- [ ] Eastern European
- [ ] European
- [ ] Filipino
- [ ] Japanese
- [ ] Korean
- [ ] Vietnamese
- [ ] Middle Eastern
- [ ] Non-Hispanic Other (please specify)

- [ ] Prefer not to answer

What is the primary language you speak or use at home?

- ◯ English
- ◯ Arabic
- ◯ Farsi
- ◯ Spanish
- ◯ Tagalog
- ◯ Vietnamese
- ◯ Other (please specify)

What best describes your sexual orientation?

- ◯ Gay or Lesbian
- ◯ Heterosexual or Straight
- ◯ Bisexual
- ◯ Questioning or unsure of sexual orientation
- ◯ Queer
- ◯ Another sexual orientation (please specify)
- ◯ Prefer not to answer

Do you have a disability, defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

If Yes, select domains

- ☐ Communication domain: Difficulty seeing,
- ☐ Communication domain: Difficulty hearing, or having speech understood
- ☐ Communication domain: Other (please specify)

- ☐ Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)
- ☐ Physical/mobility domain
- ☐ Chronic health condition (including, but not limited to, chronic pain)
- ☐ Other (please specify)

Are you a veteran?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

What was your assigned sex at birth?

- ◯ Male
- ◯ Female
- ◯ Other (please specify)

[ ]

- ◯ Prefer not to answer

Please mark the gender identity that best describes you currently.

- ◯ Male
- ◯ Female
- ◯ Transgender
- ◯ Genderqueer
- ◯ Questioning or unsure of gender identity
- ◯ Another gender identity (please specify)

[ ]

- ◯ Prefer not to answer

Submit

Appendix 8: Survey Tool

Event Feedback Survey

Date: ____/____/2020 ☐ AM ☐ PM

1. **Overall, how satisfied were you with this event?**
   - ☐ Very Satisfied
   - ☐ Satisfied
   - ☐ Somewhat Satisfied
   - ☐ Not at all Satisfied
2. **How convenient was this location for you?**
   - ☐ Very Convenient
   - ☐ Convenient
   - ☐ Somewhat Convenient
   - ☐ Not at all Convenient
3. **The day of week of this event was a good fit for your schedule**
   - ☐ Agree
   - ☐ Somewhat Agree
   - ☐ Somewhat Disagree
   - ☐ Disagree
4. **The time of day of this event was a good fit for your schedule**
   - ☐ Agree
   - ☐ Somewhat Agree
   - ☐ Somewhat Disagree
   - ☐ Disagree
5. **The topics covered at today's event were useful**
   - ☐ Agree
   - ☐ Somewhat Agree
   - ☐ Somewhat Disagree
   - ☐ Disagree
6. **How did you learn of this event?**
   - ☐ Flyer
   - ☐ Friend/Colleague/Family Member
   - ☐ Email from: _____
   - ☐ Newspaper Ad
   - ☐ Social Media
   - ☐ Other: _____

Do you have suggestions for how these events could be improved? [open ended]

Do you have any other comments to share with us? [open ended]

The following demographic data collected on this form will be used strictly to generate summary reports about community engagement forums held by County of San Diego HHSA Behavioral Health services.

1. What is your age group? (Please select one)
   - ☐ age 0-15 years old
   - ☐ age 16-25 years old
   - ☐ age 25-59 years old
   - ☐ age 60 years old or over
   - ☐ Prefer not to answer

2. What is your race? (Check all that apply)
   - ☐ American Indian or Alaskan Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or other Pacific Islander
   - ☐ White
   - ☐ Other (please specify) _____
   - ☐ Prefer not to answer

3. Are you of any following origin? (Select all that apply)
   - ☐ Hispanic or Latino:
     - ☐ Caribbean
     - ☐ Central American
     - ☐ Mexican/Mexican-American/Chicano
     - ☐ Puerto Rican
     - ☐ South American
     - ☐ Other (please specify) _____
   - ☐ Non-Hispanic or Non-Latino:
     - ☐ African
     - ☐ Asian Indian/South Asian
     - ☐ Cambodian
     - ☐ Chinese
     - ☐ Eastern European
     - ☐ European
     - ☐ Filipino
     - ☐ Japanese
     - ☐ Korean
     - ☐ Middle Eastern
     - ☐ Vietnamese
     - ☐ Other (please specify) _____
   - ☐ Prefer not to answer

4. What is the **primary** language you speak or use at home other than English? (Please select one)
   - ☐ English
   - ☐ Arabic
   - ☐ Farsi
   - ☐ Spanish
   - ☐ Tagalog
   - ☐ Vietnamese
   - ☐ Other (please specify) _____

5. What best describes your sexual orientation? (Please select one)
   - ☐ Gay or Lesbian
   - ☐ Heterosexual or Straight
   - ☐ Bisexual
   - ☐ Questioning or unsure of sexual orientation
   - ☐ Queer
   - ☐ Another sexual orientation (please specify) _____
   - ☐ Prefer not to answer

6. Do you have a disability, defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness?
   - ☐ Yes
     - Communication domain:
       - ☐ Difficulty seeing,
       - ☐ Difficulty hearing, or having speech understood
       - ☐ Other (please specify) _____
     - ☐ Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)
     - ☐ Physical/mobility domain
     - ☐ Chronic health condition (including, but not limited to, chronic pain)
     - ☐ Other (please specify) _____
   - ☐ No
   - ☐ Prefer not to answer

7. Are you a veteran? (Please select one)
   - ☐ Yes
   - ☐ No
   - ☐ Prefer not to answer

8. What was your assigned sex at birth? (Please select one)
   - ☐ Male
   - ☐ Female
   - ☐ Other (please specify) _____
   - ☐ Prefer not to answer

9. Please mark the gender identity that best describes you currently. (Please select one)
   - ☐ Male
   - ☐ Female
   - ☐ Transgender
   - ☐ Genderqueer
   - ☐ Questioning or unsure of gender identity
   - ☐ Another gender identity (please specify) _____
   - ☐ Prefer not to answer

10. Do you identify with any of these *additional* groups? (Select all that apply)
   - ☐ Immigrant
   - ☐ Refugee/Newcomer
   - ☐ Asylee
   - ☐ Veterans/Military
   - ☐ Homeless
   - ☐ African
   - ☐ Chaldean
   - ☐ LGBTQI
   - ☐ Prefer not to answer

Appendix 9
Behavioral Health Services Community Engagement Demographics by Session Fiscal Year 2020-21

Reported by

The Institute for Public Health
School of Public Health
San Diego State University

March 2021



SAN DIEGO STATE UNIVERSITY

Institute for Public Health

Table 1. Participants by Community Listening Session

Date	Time	Audience	Pre-registered	Attended
12/01	10:00 am Weekday	BHS Service Providers Community Listening Session	156	113
12/12	11:00 am Weekend	Family and Youth Community Listening Session	126	45
		Total	**282**	**158**

Table 2. Community Listening Sessions Participant Age Groups

Age Group	Total n	% [1]	12/1 n	% [1]	12/12 n	% [1]
age 0-15 years old	7	5%	1	1%	6	15%
age 16-25 years old	17	12%	3	3%	14	36%
age 25-59 years old	92	64%	78	75%	14	36%
age 60 years old or over	22	15%	20	19%	2	5%
Declined to answer	5	3%	2	2%	3	8%
Total	**143**		**104**		**39**	

[1]Totals may not sum to 100% due to rounding.

Table 3. Community Listening Sessions Participant Race

Race	Total n	% [1]	12/1 n	% [1]	12/12 n	% [1]
American Indian or Alaska Native	1	1%	0	0%	1	3%
Asian	15	11%	8	8%	7	18%
Black or African American	6	4%	4	4%	2	5%
Native Hawaiian or Other Pacific Islander	1	1%	0	0%	1	3%
White	84	60%	68	67%	16	42%
Other [2]	11	8%	9	9%	2	5%
More than one race	4	3%	1	1%	3	8%
Declined to answer	17	12%	11	11%	6	16%
Total	**139**		**101**		**38**	

[1]Totals may not sum to 100% due to rounding.
[2]Other responses included: Hispanic/Latino (n=3); Mexican (n=3); Biracial (n=1); Mestizo (n=1); not specified (n=3)

Table 4. Community Listening Sessions Participant Ethnicity

Ethnicity	Total n	% [1]	12/1 n	% [1]	12/12 n	% [1]
Hispanic or Latino	**43**	**32%**	**28**	**29%**	**15**	**43%**
Caribbean	0	0%	0	0%	0	0%

Central American	2	1%	2	2%	0	0%
Mexican/Mexican American/Chicano	22	15%	14	14%	8	23%
Puerto Rican	0	0%	0	0%	0	0%
South American	1	1%	1	1%	0	0%
Other	0	0%	0	0%	0	0%
Non-Hispanic or Non-Latino	**66**	**50%**	**50**	**51%**	**16**	**46%**
African	2	2%	2	2%	0	0%
Asian Indian/South Asian	4	3%	2	2%	2	6%
Cambodian	0	0%	0	0%	0	0%
Chinese	2	2%	2	2%	0	0%
Eastern European	3	2%	3	3%	0	0%
European	23	17%	19	19%	4	11%
Filipino	4	3%	1	1%	3	9%
Japanese	0	0%	0	0%	0	0%
Korean	1	1%	1	1%	0	0%
Middle Eastern	0	0%	0	0%	0	0%
Vietnamese	1	1%	1	1%	0	0%
Other[2]	1	1%	0	0%	1	3%
More than one ethnicity	**8**	**6%**	**7**	**7%**	**1**	**3%**
Declined to answer	**16**	**12%**	**13**	**13%**	**3**	**9%**
Total	**133**		**98**		**35**	

[1]Totals may not sum to 100% due to rounding.
[2]Other response: a specific ethnicity was not provided

Table 5. Community Listening Sessions Participant Primary Language Used

Primary Language	Total n	%[1]	12/1 n	%[1]	12/12 n	%[1]
English	124	87%	93	89%	31	79%
Spanish	17	12%	10	10%	7	18%
Tagalog	1	1%	1	1%	0	0%
Other[2]	1	1%	0	0%	1	3%
Total	**143**		**104**		**39**	

[1]Totals may not sum to 100% due to rounding.
[2]Other response included: Burmese

Table 6. Community Listening Sessions Participant Sexual Orientation

Sexual Orientation	Total n	%[1]	12/1 n	%[1]	12/12 n	%[1]
Gay or Lesbian	9	7%	8	8%	1	3%
Straight or Heterosexual	101	74%	76	74%	29	74%
Bisexual	3	2%	2	2%	1	3%
Queer	5	4%	5	5%	0	0%

Another sexual orientation	0	0%	0	0%	0	0%
Declined to answer	19	14%	12	12%	8	21%
Total	**137**		**103**		**39**	

[1]Totals may not sum to 100% due to rounding.

Table 7. Disability of Community Listening Sessions Participants

Do you have a disability?	Total n	%[1]	12/1 n	%[1]	12/12 n	%[1]
Yes	**7**	**5%**	**6**	**6%**	**1**	**3%**
If yes[2]						
Communication domain: Difficulty seeing	0		0		0	
Communication domain: Difficulty hearing, or having speech understood	0		0		0	
Communication domain: Other	0		0		0	
Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)	3		2		1	
Physical/mobility domain	2		2		0	
Chronic health condition (including, but not limited to, chronic pain)	2		1		1	
Other[3]	1		1		0	
No	**125**	**87%**	**91**	**88%**	**34**	**87%**
Declined to answer	**11**	**8%**	**7**	**7%**	**4**	**10%**
Total	**143**		**104**		**39**	

[1]Totals may not sum to 100% due to rounding.
[2]Multiple responses to specify disabilities
[3]Other response included: epilepsy (n=1)

Table 8. Community Listening Sessions Participant Veteran Status

Are you a veteran?	Total n	%[1]	12/1 n	%[1]	12/12 n	%[1]
Yes	2	1%	1	1%	1	3%
No	133	94%	97	94%	36	95%
Declined to answer	6	4%	5	5%	1	3%
Total	**141**		**103**		**38**	

[1]Totals may not sum to 100% due to rounding.

Table 9. Community Listening Sessions Participant Sex at Birth

Sex at Birth	Total n	%[1]	12/1 n	%[1]	12/12 n	%[1]
Male	26	18%	19	18%	7	18%
Female	109	76%	80	77%	29	74%
Other	0	0%	0	0%	0	0%

Declined to answer	8	6%	5	5%	3	8%
Total	**143**		**104**		**39**	

[1]Totals may not sum to 100% due to rounding.

Table 10. Community Listening Sessions Participant Current Gender Identity

Current Gender Identity	Total n	%[1]	12/1 n	%[1]	12/12 n	%[1]
Male	26	18%	19	18%	7	18%
Female	107	75%	78	75%	29	74%
Transgender	0	0%	0	0%	0	0%
Genderqueer	1	1%	1	1%	0	0%
Questioning or unsure of gender identity	0	0%	0	0%	0	0%
Another gender identity	0	0%	0	0%	0	0%
Declined to answer	9	6%	6	6%	3	8%
Total	**143**		**104**		**39**	

[1]Totals may not sum to 100% due to rounding.

Participants were asked whether they identified with any listed special populations; each registrant could choose as many categories as were applicable. The number and total percentage of people who identified with each group is listed in Table 11 below.

Table 11. Community Listening Sessions Participant Special Population Groups Multiple Responses Question[1]

Special Population Groups	Total n	%[2]	12/1 n	%[2]	12/12 n	%[2]
Community Member	49	35%	24	23%	25	66%
Consumer/Client	6	4%	5	5%	1	3%
Family Member of Consumer	11	8%	8	8%	3	8%
Law Enforcement	0	0%	0	0%	0	0%
School Personnel	9	6%	2	2%	7	18%
Provider	91	64%	85	82%	6	16%
Immigrant	6	4%	3	3%	3	8%
Refugee/Newcomer	4	3%	2	2%	2	5%
Asylee	1	1%	1	1%	0	0%
Veterans/Military	5	4%	4	4%	1	3%
Homeless	4	3%	3	3%	1	3%
African	0	0%	0	0%	0	0%
Chaldean	0	0%	0	0%	0	0%
LGBTQI	9	6%	7	7%	2	5%

None of the Above	19	13%	12	12%	7	18%
Total Respondents	**142**		**104**		**38**	

[1]Percentages and totals are based on respondents

[2]Totals may not sum to 100% due to rounding.

Community Listening Session attendees were asked to provide their ZIP codes, which were then grouped into six San Diego County HHSA-defined regions. The number and proportion of attendees from each region is provided in Table 12. The Central and North Central regions had the most representation, and the North Coastal region had the least.

Table 12. Community Listening Sessions Participant Region

Region	Total n	%[1]	12/1 n	%[1]	12/12 n	%[1]
Central	39	28%	32	32%	7	18%
North Central	34	25%	28	28%	6	15%
North Inland	25	18%	11	11%	14	36%
South	18	13%	11	11%	7	18%
East	14	10%	10	10%	4	10%
North Coastal	8	6%	7	7%	1	3%
Total	**133**		**99**		**39**	

[1]Totals may not sum to 100% due to rounding.

A total of 33 people attended nine focus groups. Six people attended more than one focus groups. Details about attendees at each focus group are provided in Table 13 below. Additional individuals pre-registered for the focus group but did not attend. These individuals are not represented in the data summarized in this report.

Table 13. Participants by Focus Group

Date	Time	Audience	Pre-registered	Attended
11/12 Thu	12:00pm	San Diego Trauma Informed Guide Team	9	6
11/18 Wed	3:00pm	LatinX Individuals	16	6
11/21 Sat	10:00am	Asian/Pacific Islander Individuals	6	0
12/02 Wed	7:00pm	LatinX Individuals	15	2
12/03 Thu	12:00pm	BHS Service Providers who are Essential Workers	15	2
12/05 Sat	10:00am	Loved Ones of People with Serious Mental Illness (SMI)	12	1
12/08 Tue	3:00pm	People with Serious Mental Illness (SMI)	15	4
12/08 Tue	5:30pm	Black/African American Individuals	17	3
12/15 Tue	10:00am	Loved Ones of People with Substance Use Disorders (SUD)	16	4
12/17 Wed	6:30pm	People with Substance Use Disorders (SUD)	14	0
12/29 Tue	12:00pm	Community Leaders in Rural San Diego	8	5
		Total	**143**	**33**

[1]Totals may not sum to 100% due to rounding.

Table 14. Focus Group Participant Age Groups

Age Group	Total n	%[1]	11/12 TIGT	11/18 Latinx	12/2 Latinx	12/3 BHS	12/5 SMI family	12/8 AA	12/8 SMI	12/15 SUD family	12/28 Rural
age 0-15 years old	0	0%	0	0	0	0	0	0	0	0	0
age 16-25 years old	0	0%	0	0	0	0	0	0	0	0	0
age 25-59 years old	22	67%	5	5	0	1	0	3	2	1	5
age 60 years old or over	10	30%	1	1	2	1	1	0	2	2	0
Declined to answer	1	3%	0	0	0	0	0	0	0	1	0
Total	**33**		**6**	**6**	**2**	**2**	**1**	**3**	**4**	**4**	**5**

[1]Totals may not sum to 100% due to rounding.

Table 15. Focus Group Participant Race

Race	Total n	%[1]	11/12 TIGT	11/18 Latinx	12/2 Latinx	12/3 BHS	12/5 SMI family	12/8 AA	12/8 SMI	12/15 SUD family	12/28 Rural
American Indian or Alaska Native	1	3%	0	0	0	0	0	0	0	0	1
Asian	2	6%	1	0	0	0	0	1	0	0	0
Black or African American	4	12%	0	1	0	1	0	2	0	0	0
Native Hawaiian or Other Pacific Islander	0	0%	0	0	0	0	0	0	0	0	0
White	20	61%	4	3	2	1	1	0	3	4	2
Other[2]	1	3%	0	1	0	0	0	0	0	0	0
More than one race	4	12%	1	1	0	0	0	0	1	0	1
Declined to answer	1	3%	0	0	0	0	0	0	0	0	1
Total	**33**		**6**	**6**	**2**	**2**	**1**	**3**	**4**	**4**	**5**

[1]Totals may not sum to 100% due to rounding.
[2]Other response: a specific ethnicity was not provided

Table 16. Focus Group Participant Ethnicity

Ethnicity	Total n	%[1]	11/12 TIGT	11/18 Latinx	12/2 Latinx	12/3 BHS	12/5 SMI family	12/8 AA	12/8 SMI	12/15 SUD family	12/28 Rural
Hispanic or Latino	**6**	**18%**	**0**	**3**	**1**	**0**	**0**	**0**	**0**	**2**	**0**
Caribbean	0	0%	0	0	0	0	0	0	0	0	0
Central American	0	0%	0	0	0	0	0	0	0	0	0
Mexican/Mexican American/Chicano	1	3%	0	1	0	0	0	0	0	0	0
Puerto Rican	0	0%	0	0	0	0	0	0	0	0	0
South American	1	3%	0	0	1	0	0	0	0	0	0
Other	0	0%	0	0	0	0	0	0	0	0	0
Non-Hispanic or Non-Latino	**22**	**67%**	**5**	**2**	**1**	**2**	**1**	**3**	**4**	**2**	**2**
African	3	9%	0	1	0	1	0	1	0	0	0
Asian Indian/South Asian	1	3%	1	0	0	0	0	0	0	0	0
Cambodian	0	0%	0	0	0	0	0	0	0	0	0
Chinese	0	0%	0	0	0	0	0	0	0	0	0
Eastern European	1	3%	1	0	0	0	0	0	0	0	0
European	9	27%	0	0	1	1	1	0	3	2	1
Filipino	1	3%	0	1	0	0	0	0	0	0	0
Japanese	0	0%	0	0	0	0	0	0	0	0	0
Korean	0	0%	0	0	0	0	0	0	0	0	0
Middle Eastern	0	0%	0	0	0	0	0	0	0	0	0
Vietnamese	0	0%	0	0	0	0	0	0	0	0	0
Other	0	0%	0	0	0	0	0	0	0	0	0
More than one ethnicity	**1**	**3%**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Declined to answer	**4**	**12%**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3**
Total	**33**		**6**	**6**	**2**	**2**	**1**	**3**	**4**	**4**	**5**

[1]Totals may not sum to 100% due to rounding.

Table 17. Focus Group Participant Primary Language Used

Primary Language	Total n	%[1]	11/12 TIGT	11/18 Latinx	12/2 Latinx	12/3 BHS	12/5 SMI family	12/8 AA	12/8 SMI	12/15 SUD family	12/28 Rural
English	31	94%	6	5	2	2	1	2	4	4	5
Spanish	1	3%	0	1	0	0	0	0	0	0	0
Vietnamese	1	3%	0	0	0	0	0	1	0	0	0
Total	**33**		**6**	**6**	**2**	**2**	**1**	**3**	**4**	**4**	**5**

[1]Totals may not sum to 100% due to rounding.

Table 18. Focus Group Participant Sexual Orientation

Sexual Orientation	Total n	%[1]	11/12 TIGT	11/18 Latinx	12/2 Latinx	12/3 BHS	12/5 SMI family	12/8 AA	12/8 SMI	12/15 SUD family	12/28 Rural
Gay or Lesbian	1	3%	1	0	0	0	0	0	0	0	0
Straight or Heterosexual	28	85%	4	6	2	2	1	3	3	3	4
Bisexual	0	0%	0	0	0	0	0	0	0	0	0
Queer	0	0%	0	0	0	0	0	0	0	0	0
Another sexual orientation	1	3%	0	0	0	0	0	0	1	0	0
Declined to answer	3	9%	1	0	0	0	0	0	0	1	1
Total	**33**		**6**	**6**	**2**	**2**	**1**	**3**	**4**	**4**	**5**

[1]Totals may not sum to 100% due to rounding.

Table 19. Disability of Focus Group Participants

Do you have a disability?	Total n	%[1]	11/12 TIGT	11/18 Latinx	12/2 Latinx	12/3 BHS	12/5 SMI family	12/8 AA	12/8 SMI	12/15 SUD family	12/28 Rural
Yes	**2**	**6%**	**0**	**0**	**1**	**0**	**0**	**0**	**1**	**0**	**0**
If yes[2]											
Communication domain: Difficulty seeing	1		0	0	0	0	0	0	1	0	0
Communication domain: Difficulty hearing, or having speech understood	0		0	0	0	0	0	0	0	0	0

Communication domain: Other	0		0	0	0	0	0	0	0	0	0
Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)	2		0	0	1	0	0	0	1	0	0
Physical/mobility domain	1		0	0	0	0	0	0	1	0	0
Chronic health condition (including, but not limited to, chronic pain)	2		0	0	1	0	0	0	1	0	0
Other	0		0	0	0	0	0	0	0	0	0
No	**31**	**94%**	**6**	**6**	**1**	**3**	**2**	**3**	**6**	**6**	**5**
Declined to answer	**0**	**0%**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total	**33**		**6**	**6**	**2**	**3**	**2**	**3**	**7**	**6**	**5**

[1]Totals may not sum to 100% due to rounding.
[2]Multiple responses to specify disabilities

Table 20. Focus Group Participant Veteran Status

Are you a veteran?	Total n	%[1]	11/12 TIGT	11/18 Latinx	12/2 Latinx	12/3 BHS	12/5 SMI family	12/8 AA	12/8 SMI	12/15 SUD family	12/28 Rural
Yes	0	0%	0	0	0	0	0	0	0	0	0
No	33	100%	6	6	2	2	1	3	4	4	5
Declined to answer	0	0%	0	0	0	0	0	0	0	0	0
Total	**33**		**6**	**6**	**2**	**2**	**1**	**3**	**4**	**4**	**5**

[1]Totals may not sum to 100% due to rounding.

Table 21. Focus Group Participant Sex at Birth

Sex at Birth	Total n	%[1]	11/12 TIGT	11/18 Latinx	12/2 Latinx	12/3 BHS	12/5 SMI family	12/8 AA	12/8 SMI	12/15 SUD family	12/28 Rural

Male	10	30%	1	2	1	1	1	0	2	0	2
Female	22	67%	4	4	1	1	0	3	2	4	3
Other	0	0%	0	0	0	0	0	0	0	0	0
Declined to answer	1	3%	1	0	0	0	0	0	0	0	0
Total	**33**		**6**	**6**	**2**	**3**	**2**	**3**	**7**	**6**	**5**

[1]Totals may not sum to 100% due to rounding.

Table 22. Focus Group Participant Current Gender Identity

Current Gender Identity	Total n	%[1]	11/12 TIGT	11/18 Latinx	12/2 Latinx	12/3 BHS	12/5 SMI family	12/8 AA	12/8 SMI	12/15 SUD family	12/28 Rural
Male	10	30%	1	2	1	1	1	0	2	0	2
Female	22	67%	4	4	1	1	0	3	2	4	3
Transgender	0	0%	0	0	0	0	0	0	0	0	0
Genderqueer	0	0%	0	0	0	0	0	0	0	0	0
Questioning or unsure of gender identity	0	0%	0	0	0	0	0	0	0	0	0
Another gender identity	0	0%	0	0	0	0	0	0	0	0	0
Declined to answer	1	3%	1	0	0	0	0	0	0	0	0
Total	**33**		**6**	**6**	**2**	**2**	**1**	**3**	**4**	**4**	**5**

[1]Totals may not sum to 100% due to rounding.

Participants were asked whether they identified with any listed special populations; each registrant could choose as many categories as were applicable. The number and total percentage of people who identified with each group is listed in Table 23 below.

Table 23. Focus Group Participant Special Population Groups Multiple Responses Question[1]

Special Population Groups	Total n	%[2]	11/12 TIGT	11/18 Latinx	12/2 Latinx	12/3 BHS	12/5 SMI family	12/8 AA	12/8 SMI	12/15 SUD family	12/28 Rural
Community Member	21	64%	2	3	1	2	1	3	4	4	1
Consumer/Client	9	27%	1	1	2	1	1	0	2	1	0

Family Member of Consumer	8	24%	2	2	0	0	0	0	1	3	0
Law Enforcement	0	0%	0	0	0	0	0	0	0	0	0
School Personnel	6	18%	2	0	0	0	0	0	0	0	4
Provider	17	52%	5	4	1	0	0	2	1	1	3
Immigrant	5	15%	0	2	0	1	0	0	1	1	0
Refugee/Newcomer	1	3%	0	0	0	0	0	0	1	0	0
Asylee	1	3%	0	0	0	0	0	0	0	0	0
Veterans/Military	1	3%	0	0	0	0	0	0	1	0	0
Homeless	1	3%	0	0	0	0	0	0	1	0	0
African	0	0%	0	0	0	1	0	0	0	0	0
Chaldean	1	3%	0	0	0	0	0	0	0	0	0
LGBTQI	6	18%	1	0	0	0	0	0	0	0	0
None of the Above	0	0%	0	0	0	0	0	0	0	0	0
Total Respondents	**33**		**6**	**6**	**2**	**2**	**1**	**3**	**4**	**4**	**5**

[1]Percentages and totals are based on respondents

[2]Totals may not sum to 100% due to rounding.

Focus Group attendees were asked to provide their ZIP codes, which were then grouped into six San Diego County HHSA-defined regions. The number and proportion of attendees from each region is provided in Table 24. The Central region had the most representation, and the North Coastal and North Inland regions had the least.

Table 24. Focus Group Participant Region

Region	Total n	%[1]	11/12 TIGT	11/18 Latinx	12/2 Latinx	12/3 BHS	12/5 SMI family	12/8 AA	12/8 SMI	12/15 SUD family	12/28 Rural
Central	12	36%	1	2	1	1	1	3	2	1	0
East	10	30%	2	0	0	0	0	0	1	2	5
North Central	6	18%	2	1	1	1	0	0	0	1	0
South	3	9%	0	3	0	0	0	0	0	0	0
North Inland	1	3%	1	0	0	0	0	0	0	0	0

North Coastal	1	3%	0	0	0	0	0	0	1	0	0
Total	**33**		**6**	**6**	**2**	**2**	**1**	**3**	**4**	**4**	**5**

[1]Totals may not sum to 100% due to rounding.

APPENDIX G

MHSA ISSUE RESOLUTION PROCESS

Mental Health Services Act (MHSA) Issue Resolution Process
Updated April 2021

Purpose:

This procedure supplements the Beneficiary and Client Problem Resolution Policy and Process, which provides detailed guidelines for addressing grievances and appeals regarding services, treatment and care, by providing a process for addressing issues, complaints and grievances about MHSA planning and process.

The Department of Health Care Services (DHCS) requires that the local issue resolution process be exhausted before accessing State venues such as the Mental Health Services Oversight and Accountability Commission (MHSOAC) or the California Mental Health Planning Council (CMHPC) to seek issue resolution or to file a complaint or grievance.

The County of San Diego Health and Human Services Agency, Behavioral Health Services (BHS) has adopted an issue resolution process for filing and resolving issues related to the MHSA community program planning process, and consistency between program implementation and approved plans.

BHS is committed to:

- Addressing issues regarding MHSA in an expedient and appropriate manner;
- Providing several avenues to file an issue, complaint or grievance;
- Ensuring assistance is available, if needed, for the client/family member/provider/community member to file their issue; and
- Honoring the Issue Filer's desire for anonymity.

Types of MHSA issues to be resolved in this process:

- Appropriate use of MHSA funds
    - Allegations of fraud, waste, and abuse of funds are excluded from this process. Allegations of this type will be referred directly to the County Compliance Office for investigation.
- Inconsistency between approved MHSA Plan and implementation;
- San Diego County Community Program Planning Process.

Process:

- An individual may file an issue at any point and via any avenue within the system. These avenues include but are not limited to: the BHS Director, BHS Assistant Directors, BHS Deputy Directors, BHS Councils, County of San Diego Compliance Officer, Consumer and Family Liaisons, Patient Advocacy Program, and BHS providers.
- The MHSA issue shall be forwarded to the Consumer and Family Liaisons, RI International and NAMI San Diego, for review within three (3) business days of receipt.
- Consumer and Family Liaisons (CFL) shall provide the Issue Filer a written acknowledgement of receipt of the issue, complaint or grievance within two (2) business days.
- CFL shall notify the BHS MHSA Coordinator of the issue received while maintaining anonymity of the Issue Filer within two (2) business days.
- CFL will investigate the issue.
    - CFL may convene the MHSA Issue Resolution Committee (MIRC) whose membership includes unbiased, impartial individuals who are not employed by the County of San Diego.
    - CFL will communicate with the Issue Filer every seven (7) days while the issue is being investigated and resolved.
- Upon completion of investigation, CFL/MIRC shall issue a committee report to the BHS Director.
    - Report shall include a description of the issue, brief explanation of the investigation, CFL/MIRC recommendation and the County resolution to the issue.
    - CFL shall notify the Issue Filer of the resolution in writing and provide information regarding the appeal process and State-level opportunities for additional resolution, if desired.
- The BHS Director will provide a quarterly MHSA Issue Resolution Report to the Behavioral Health Advisory Board.

Consumer and Family Liaisons:

Judi Holder
RI International
3838 Camino Del Rio North, Suite 380
San Diego, CA 92108
(858) 274-4650
Judi.Holder@recoveryinnovations.org

Valerie Hebert
NAMI San Diego
5095 Murphy Canyon Road, Suite 320
San Diego, CA 92123
(858) 634-6580
Email: CYFliaison@namisd.org or
https://namisandiego.org/cyf-liaison

APPENDIX H

COMMUNITY SUPPORTS AND SERVICES (CSS) ANNUAL REPORT FY 2019-20

FY 2019-20 Community Services and Supports (CSS)

County of San Diego Behavioral Health Services | MHSA CSS Programs

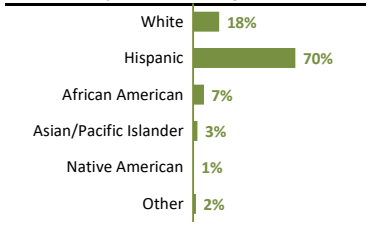
COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

Children & Youth - Full Service Partnership (CY-FSP; n=8,184)

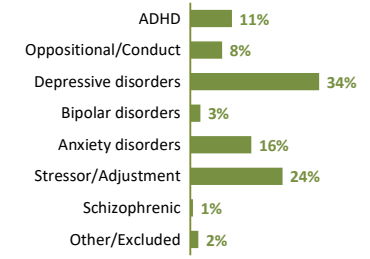
Living Situation	%
House or Apartment	93%
Correctional Facility	1%
Foster Home	3%
Group Home	<1%
Children's Shelter	<1%
Homeless	1%
Other/Unknown	1%

Language	%
English	87%
Spanish	13%
Arabic	<1%
Vietnamese	<1%
Tagalog	<1%
Farsi	<1%
Other/Unknown	<1%

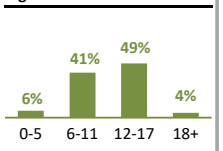
Race/Ethnicity (*excludes missing/unknown*)



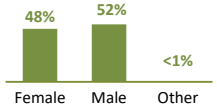
Diagnosis (*excludes missing/invalid*)



Age



Gender



CY-FSP 23% (8,184)

Children & Youth - Outreach and Engagement (CY-OE; n=0)

CY-OE programs were not active in FY 2019-20

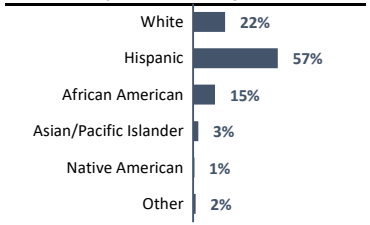
Total CSS Clients *(unduplicated)* N = 35,901

Children & Youth - System Development (CY-SD; n=3,324)

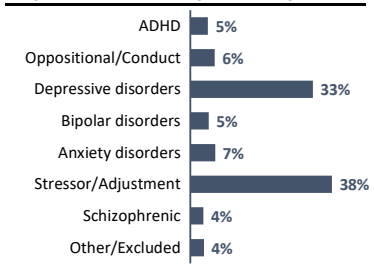
Living Situation	%
House or Apartment	60%
Correctional Facility	18%
Foster Home	8%
Group Home	6%
Children's Shelter	4%
Homeless	1%
Other/Unknown	3%

Language	%
English	90%
Spanish	9%
Arabic	<1%
Vietnamese	<1%
Tagalog	<1%
Farsi	<1%
Other/Unknown	<1%

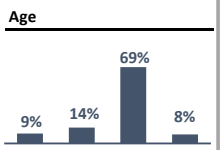
Race/Ethnicity (*excludes missing/unknown*)



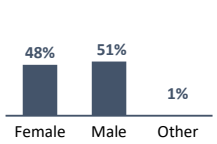
Diagnosis (*excludes missing/invalid diagnoses*)



Age



Gender

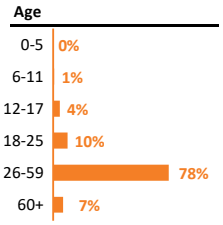


CY-SD 9% (3,324)

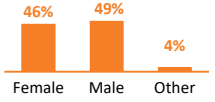
All CSS - Outreach and Engagement* (ALL-OE; n=134)

ALL-OE <1% (134)

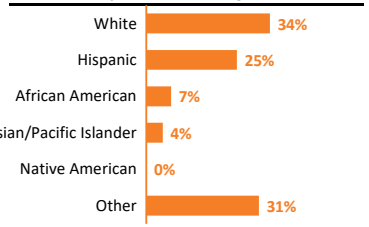
Age



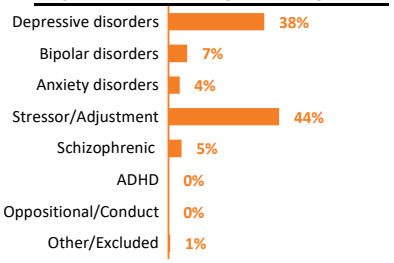
Gender



Race/Ethnicity (*excludes missing/unknown*)



Diagnosis (*excludes missing/invalid diagnoses*)



Living Situation	%
Lives Independently	93%
Justice Related	0%
Board & Care	4%
Institutional	0%
Foster Home	0%
Group Home	0%
Children's Shelter	0%
Homeless	4%
Other/Unknown	0%

Language	%
English	9%
Spanish	16%
Arabic	10%
Vietnamese	0%
Tagalog	0%
Farsi	6%
Other/Unknown	58%

**Clients may be duplicated*

Data may be impacted starting March 2020 due to COVID-19.

Note: Clients may have received services from >1 CSS category within the fiscal year. Only CSS programs that enter data into CCBH are included in this report. Some CSS programs that are excluded: Clubhouses, Emergency Transition Shelter Beds, Board & Care facilities, and Regional Recovery Centers. ***Percentages may not add up to 100% due to rounding.***

Report Date: 3/31/2021

FY 2019-20 Community Services and Supports (CSS)

County of San Diego Behavioral Health Services — MHSA CSS Programs

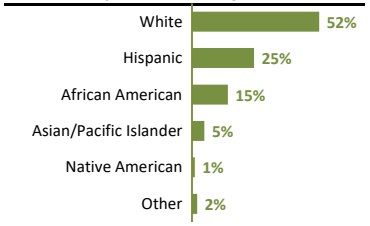
COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

TAY, Adult, Older Adult - Full Service Partnership (TAOA-FSP; n=7,314)

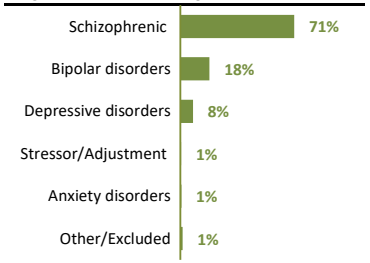
Living Situation	%
Lives Independently	55%
Board & Care	11%
Justice Related	1%
Homeless	15%
Institutional	13%
Other/Unknown	5%

Language	%
English	91%
Spanish	4%
Arabic	<1%
Vietnamese	<1%
Tagalog	<1%
Farsi	<1%
Other/Unknown	4%

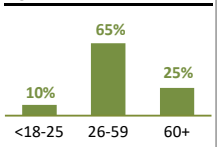
Race/Ethnicity (*excludes missing/unknown*)



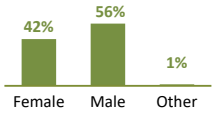
Diagnosis (*excludes missing/invalid*)



Age



Gender



TAY, Adult, Older Adult - Outreach and Engagement (TAOA-OE; n=0)

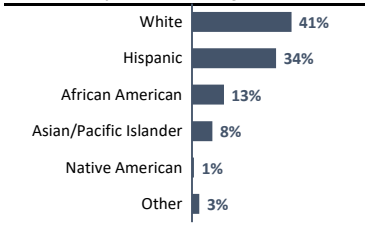
TAOA-OE programs were not active in FY 2019-20

TAY, Adult, Older Adult - System Development (TAOA-SD; n=13,284)

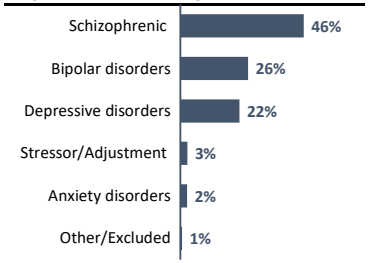
Living Situation	%
Lives Independently	61%
Board & Care	7%
Justice Related	1%
Homeless	20%
Institutional	1%
Other/Unknown	10%

Language	%
English	82%
Spanish	7%
Arabic	1%
Vietnamese	2%
Tagalog	<1%
Farsi	<1%
Other/Unknown	7%

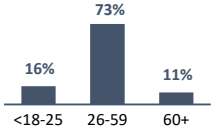
Race/Ethnicity (*excludes missing/unknown*)



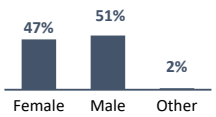
Diagnosis (*excludes missing/invalid*)



Age



Gender



Total CSS Clients *(unduplicated)* N = 35,901

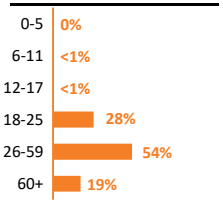
TAOA-FSP 20% (7,314)

TAOA-SD 37% (13,284)

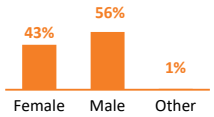
ALL-SD 27% (9,599)

All CSS - System Development† (ALL-SD; n=9,599)

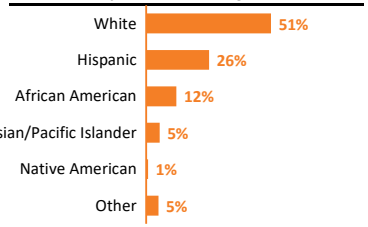
Age



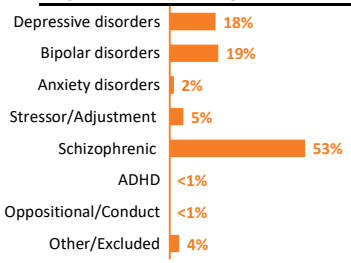
Gender



Race/Ethnicity (*excludes missing/unknown*)



Diagnosis (*excludes missing/invalid*)



Living Situation	%
Lives Independently	69%
Justice Related	1%
Board & Care	4%
Institutional	2%
Foster Home	0%
Group Home	0%
Children's Shelter	0%
Homeless	21%
Other/Unknown	3%

Language	%
English	92%
Spanish	4%
Arabic	2%
Vietnamese	<1%
Tagalog	<1%
Farsi	<1%
Other/Unknown	1%

†Clients may be duplicated

APPENDIX I

FULL-SERVICE PARTNERSHIP (FSP) OUTCOMES REPORT FY 2019-20

Full Service Partnerships OUTCOMES REPORT

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

Children, Youth & Families FSP Summary ***FY 2019-20***

What Is This?

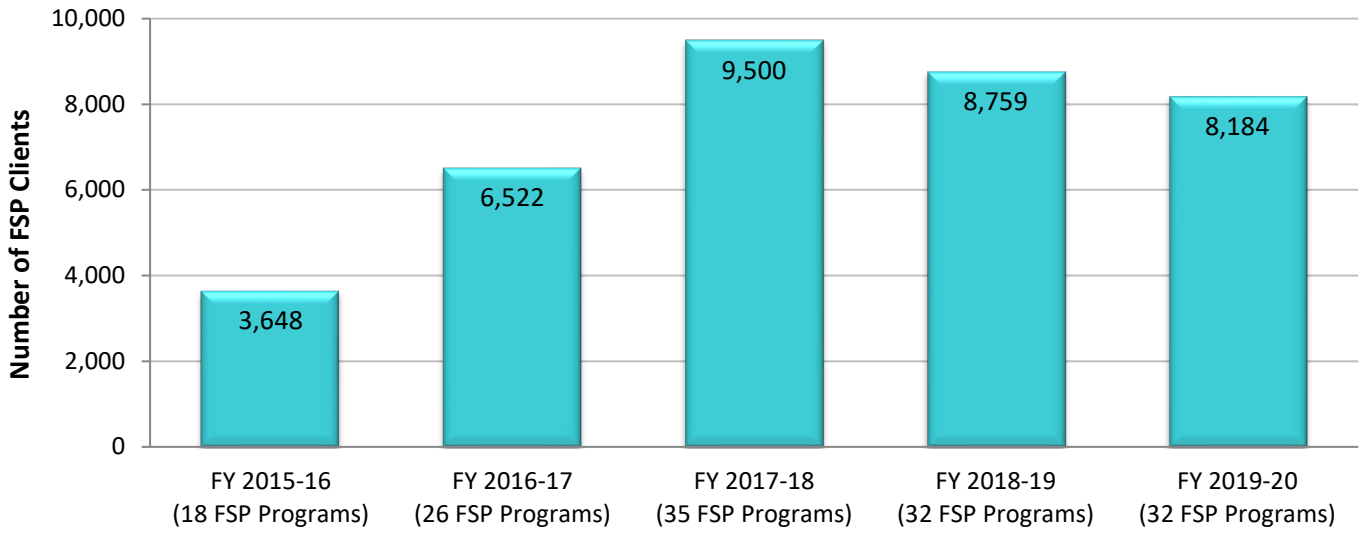
The Full Service Partnership (FSP) model offers integrated services with an emphasis on whole person wellness and promotes access to medical, social, rehabilitative, and other community services and supports as needed. An FSP provides all necessary services and supports to help clients achieve their behavioral health goals and treatment plan, and clients can access designated staff 24 hour/7 days a week. FSP services comprehensively address client and family needs through intensive services, supports, and strong connections to community resources with a focus on resilience and recovery. An FSP offers ancillary support(s), when indicated, by case managers, Substance Use Disorder (SUD) counselors addressing co-occurring conditions, rehabilitation specialists, and/or family/youth support partners. Services offered are trauma informed and promote overall wellbeing. Emphasis on partnership with the family, natural supports, primary care, education, and other systems working with the family are recognized core values.

Why Is This Important?

FSP programs support individuals and families, using a "whatever it takes" approach to establish stability and maintain engagement. The programs build on client strengths and assist in the development of abilities and skills so clients can become and remain successful. They help clients reach identified goals such as acquiring a primary care physician, increasing school attendance, improving academic performance, and reducing involvement with juvenile justice services.

Who Are We Serving?

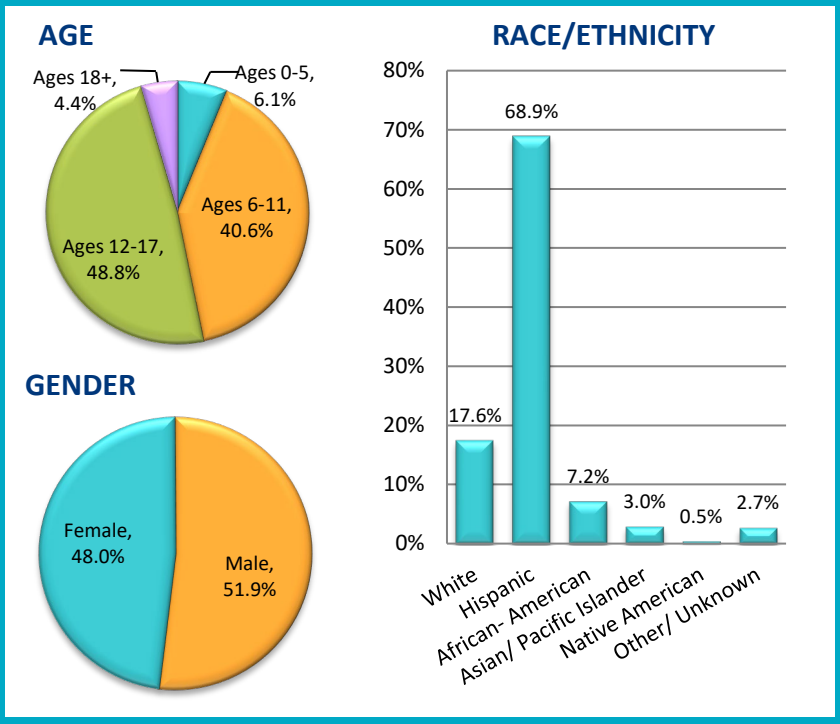
In Fiscal Year (FY) 2019-20, a total of 8,184 unduplicated clients received services through 32 CYF FSP programs, a 7% decrease from 8,759 FSP clients served in 32 CYF FSP programs in FY 2018-19.

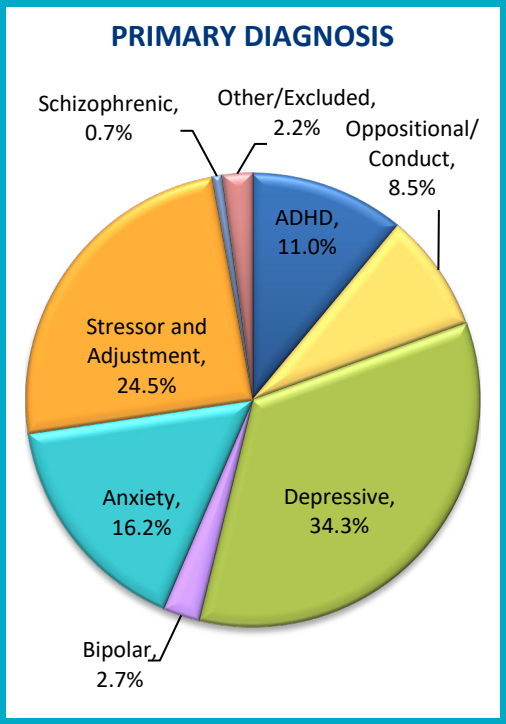


Who Are We Serving?

In FY 2019-20, FSP clients were more likely to be male and Hispanic. The most common diagnosis among FSP clients was Depressive disorder.

FSP Client Demographics and Diagnoses (N = 8,184)





NOTE: Percentages may not add up to 100% due to rounding.

Data Collection and Reporting System (DCR)

FSP providers collected client and outcomes data using the California Department of Health Care Services (DHCS) Data Collection & Reporting System (DCR). Referral sources were entered for new clients to FSP programs in FY 2019-20.

Referral Sources (N = 4,474)

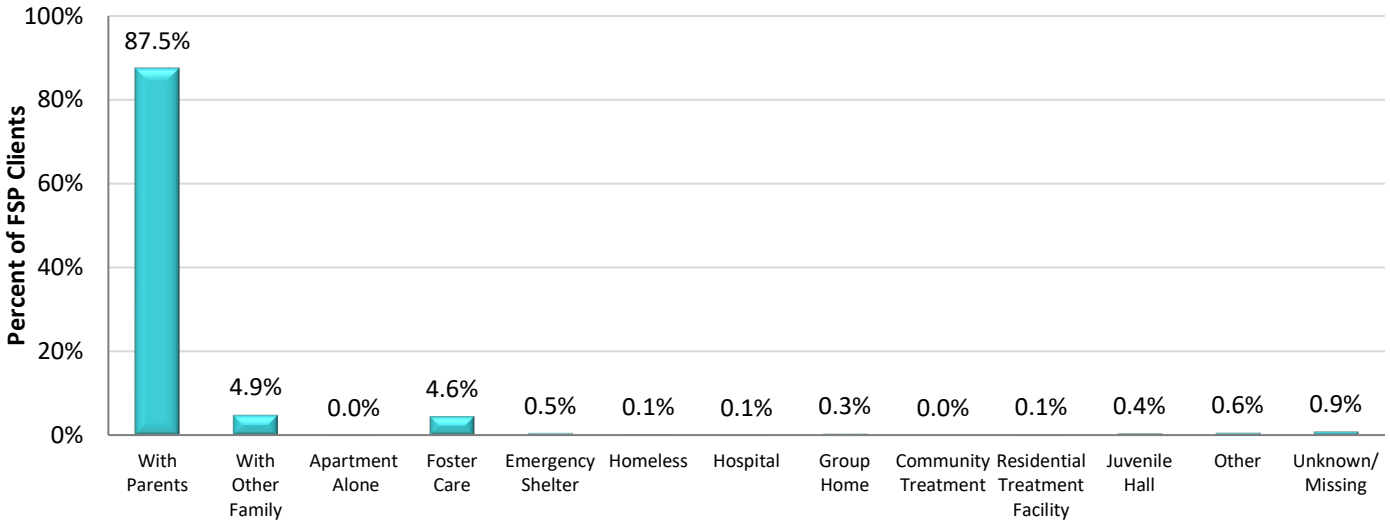
FSP referrals for clients with an intake assessment in FY 2019-20 were as follows (in order of frequency): school system (43%), family member (18%), primary care physician (9%), self-referral (9%), mental health facility (7%), social service agency (6%), other county agency (3%), Juvenile Hall (2%), acute psychiatric facility (1%), emergency room (1%), friend (<1%), homeless shelter (<1%), faith-based organization (<1%) and substance abuse facility (<1%). The remaining 2% were referred by an unknown or unspecified source.

Who Are We Serving? (continued)

Living arrangement and risk factors were entered in the DCR for new clients to FSP programs in FY 2019-20.

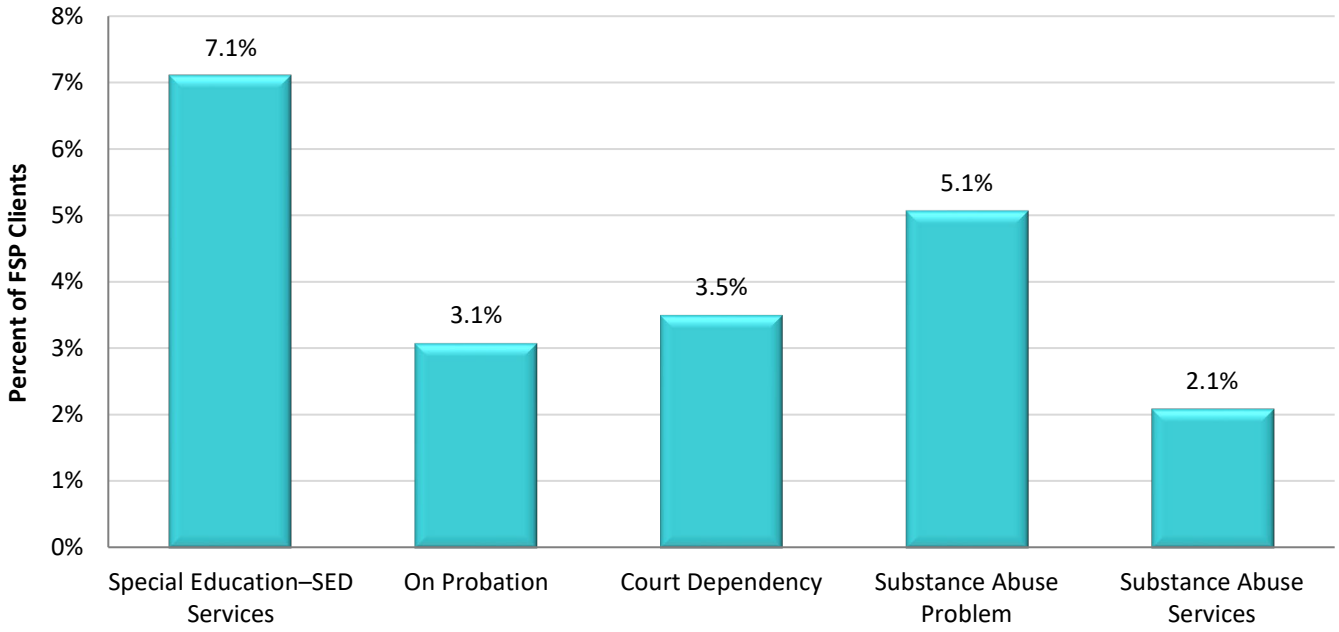
Living Arrangement at Intake (N = 4,474)*

The majority of youth entering FSP programs were living with their parents.



Risk Factors at Intake (N = 4,474)*

The most prevalent risk factor for more intensive service utilization among youth entering FSP programs was related to Special Education—Serious Emotional Disturbance (SED) Services. A total of 3,755 (84%) of clients did not have a risk factor identified on the intake form. Clients with identified risk factors may have had more than one risk factor endorsed.



**Clients with intake assessment in the DCR within FY 2019-20.*
NOTE: Percentages may not add up to 100% due to rounding.

Who Are We Serving? (continued)

Client involvement in the juvenile justice sector and emergency service provision was tracked by FSP providers.

Forensic Services

In FY 2019-20, a total of 9 FSP clients had an arrest recorded in the DCR.

Inpatient and Emergency Services

Of 8,184 unduplicated clients who received services from an FSP program in FY 2019-20, 103 (1.3%) had at least one inpatient (IP) episode and 190 (2.3%) had at least one Emergency Screening Unit (ESU) visit during the treatment episode. These numbers show decreases from 2.0% of FSP clients who had at least one IP and 3.7% of FSP clients who had at least one ESU in FY 2018-19, respectively.

Are Children Getting Better?

FSP providers collected outcomes data with the California Child and Adolescent Needs and Strengths (CANS and CANS-EC) and the Pediatric Symptom Checklist (PSC and PSC-Y). Scores were analyzed for youth discharged from FSP services in FY 2019-20 who were in services at least 60 days and who had both initial assessment and discharge scores completed. Additionally, Personal Experience Screening Questionnaire (PESQ) scores were analyzed for youth discharged from FSP programs augmented with a Substance Use Disorder (SUD) component in FY 2019-20, who were in services for at least one month.

FSP PSC Scores

The PSC measures a child's behavioral and emotional problems; it is administered to caregivers of youth ages 3 to 18, and to youth ages 11 to 18. Improvement on the PSC is evaluated three ways:

Amount of Improvement

Percentage of all clients who reported an increase in impairment (1+ point increase), no improvement (0-1 point reduction), small improvement (2-4 point reduction), medium improvement (5-8 point reduction), and a large improvement (9+ point reduction). This reflects the amount of change youth and their caregivers report from intake to discharge on the symptoms evaluated by the PSC/PSC-Y. Amount of improvement was calculated using Cohen's d effect size.

Reliable Improvement

Percentage of all clients who had at least a 6-point reduction on the PSC/PSC-Y total scale score. Reliable improvement was defined by the developers and means that the clients improved by a statistically reliable amount.

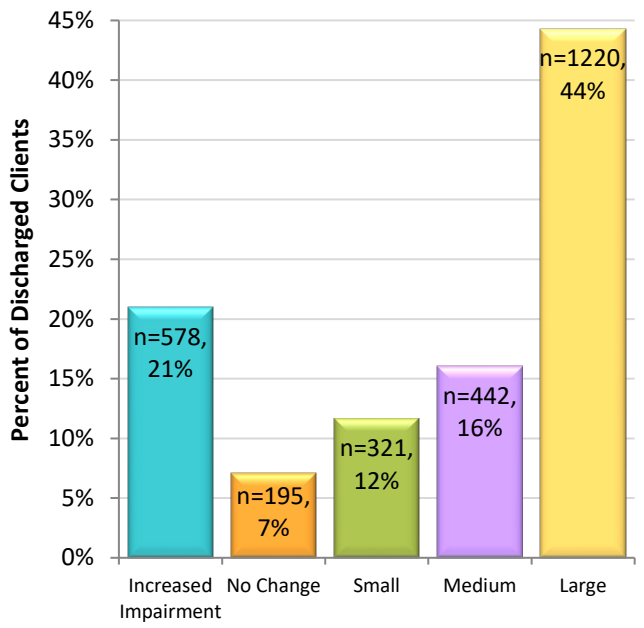
Clinically Significant Improvement

Percentage of clients who started above the clinical cutoff on at least one of the three subscales or total scale score at intake and ended below the cutoff at discharge. Additionally, these clients must have had at least a 6-point reduction on the PSC/PSC-Y total scale score. Clinically significant improvement was defined by the measures' developers and means that treatment had a noticeable genuine effect on clients' daily life and that clients are now functioning like non-impaired youth.

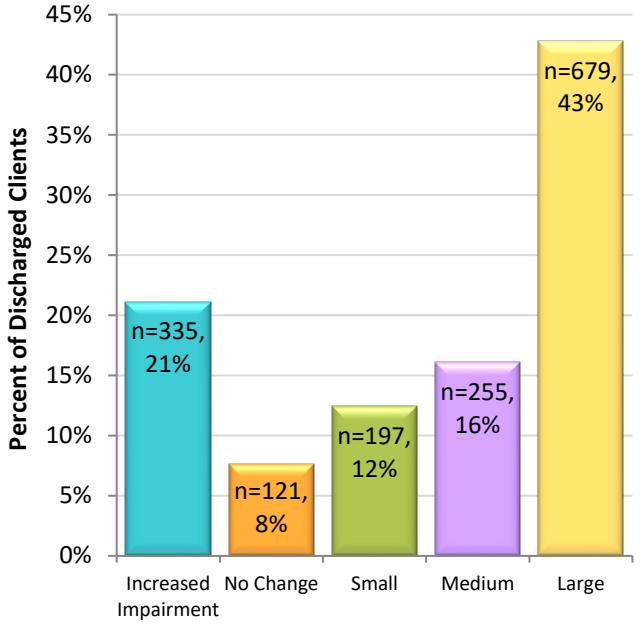
Are Children Getting Better? (continued)

PSC Amount of Improvement from Intake to Discharge

FSP Parent/Caregiver (N = 2,756)

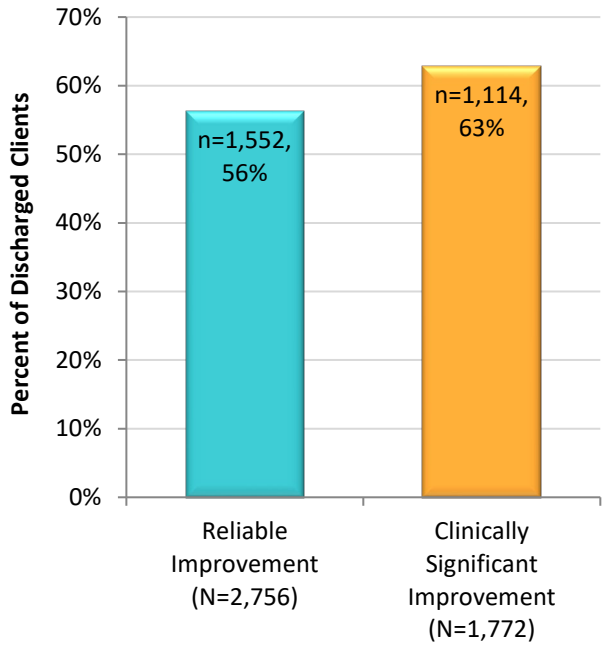


FSP Youth (N = 1,587)

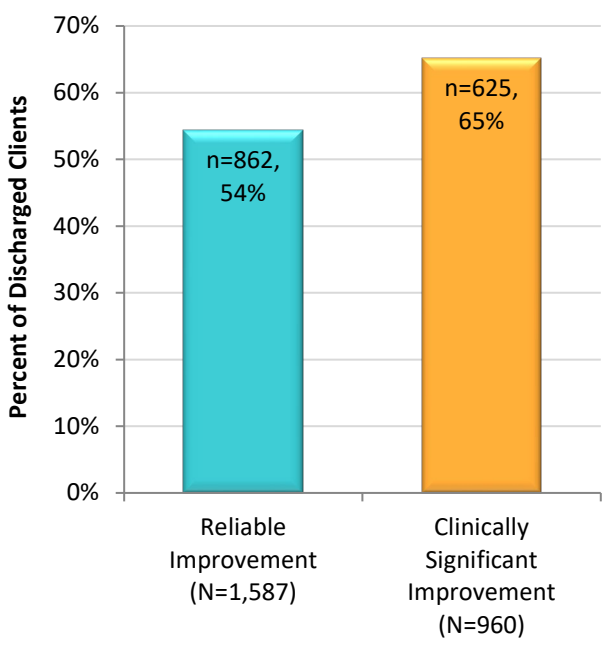


PSC Reliable and Clinically Significant Improvement from Intake to Discharge

FSP Parent/Caregiver



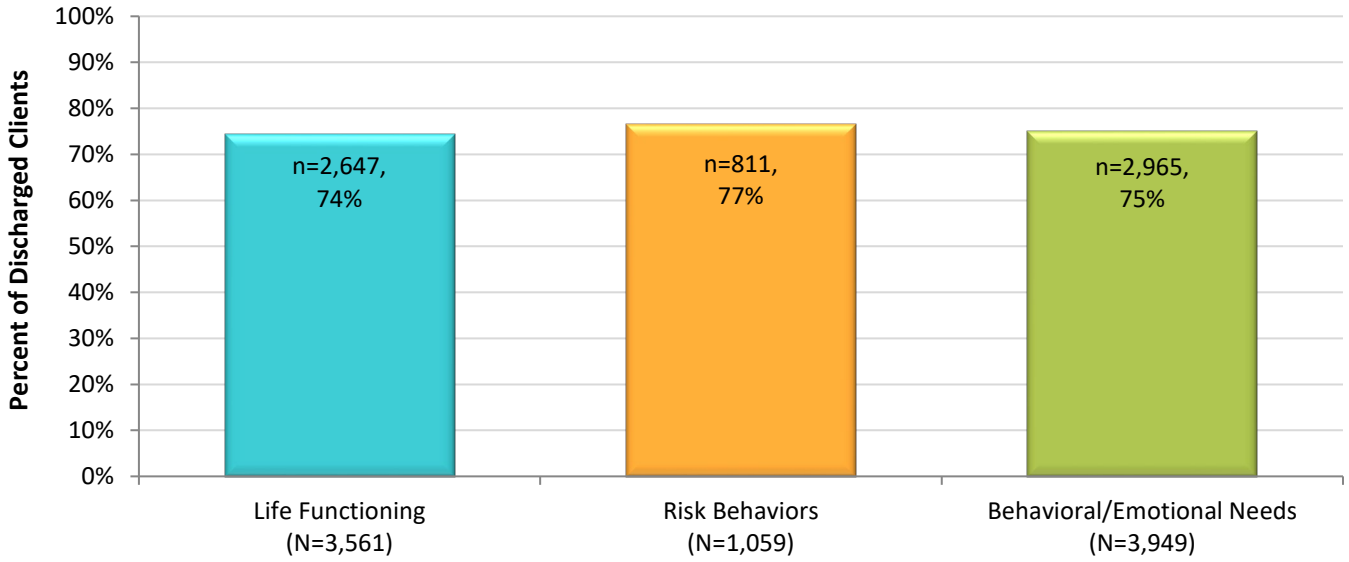
FSP Youth



Are Children Getting Better? (continued)

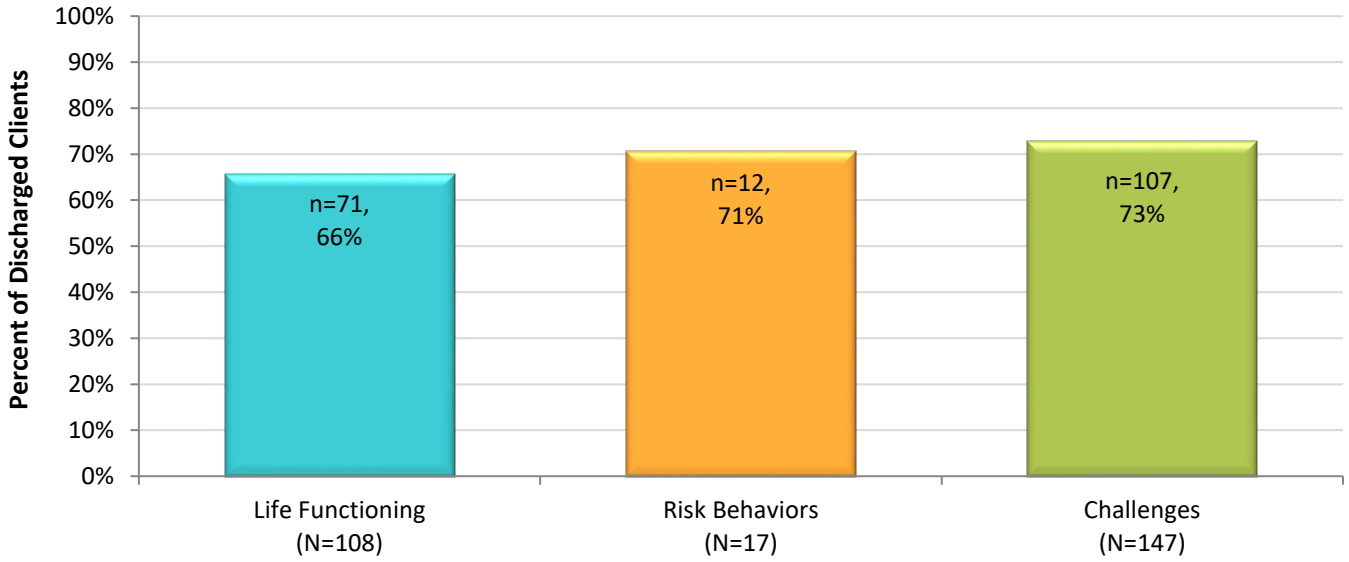
FSP CANS Scores

The CANS is a structured assessment to identify youth and family strengths and needs completed by clinicians for clients ages 6 through 21. Progress on the CANS is defined as a reduction of at least one need from initial assessment to discharge on the CANS domains: Life Functioning, Risk Behaviors, and/or Child Behavioral and Emotional needs (i.e., moving from a '2' or '3' at initial assessment to a '0' or '1' on the same item at the discharge assessment).



FSP CANS-EC Scores

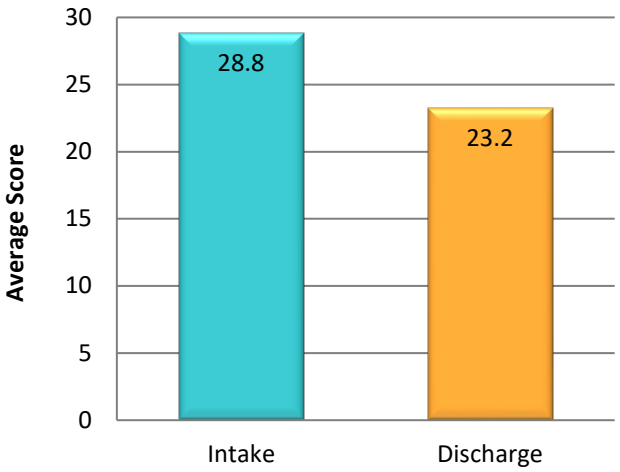
The CANS-EC is a structured assessment to identify youth and family strengths and needs completed by clinicians for clients ages 0 through 5. Progress on the CANS-EC is defined as a reduction of at least one need from initial assessment to discharge on the CANS-EC domains: Life Functioning, Risk Behaviors, and/or Challenges (i.e., moving from a '2' or '3' at initial assessment to a '0' or '1' on the same item at the discharge assessment).



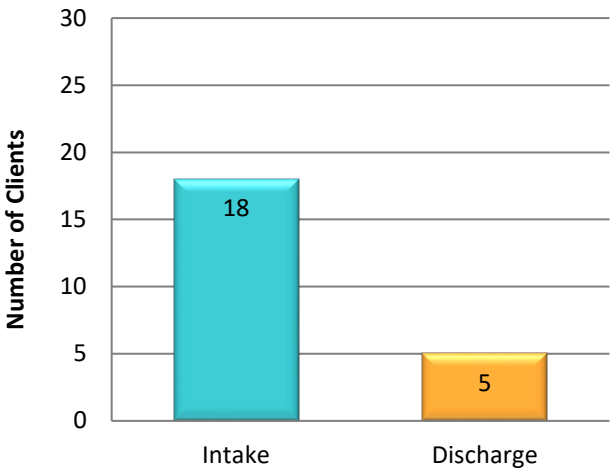
FSP PESQ Scores

The PESQ measures potential substance abuse problems and is administered to youth ages 12-18 by their Substance Use Disorder (SUD) counselor; the PESQ is only administered at FSP programs which are augmented with a dedicated SUD counselor. Scores are measured in two ways: 1) the Problem Severity scale, and 2) the total number of clients above the clinical cutpoint. For clients, a *decrease* on the Problem Severity scale is considered an improvement. For programs, a *decrease* in the number of clients scoring above the clinical cutpoint at discharge is considered an improvement. PESQ data were available for 50 discharged clients in FY 2019-20.

PESQ Severity Scale (N = 50)



PESQ Clinical Cutpoint



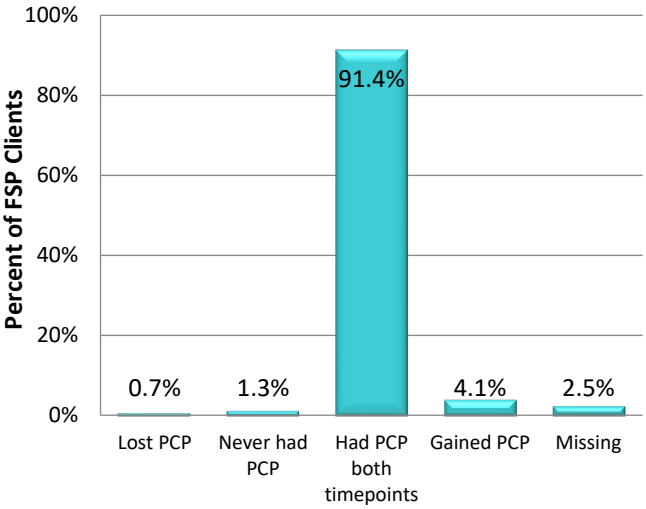


Are Children Getting Better? (continued)

FSP providers also collected client and outcomes data on primary care physician (PCP) status, school attendance, and academic performance; these were tracked in the DCR for continuing clients with multiple assessments. Analyses of these tracked outcomes were limited to clients with an intake and a 3, 6, 9, or 12 month assessment; the most recent assessment was compared to intake.

Primary Care Physician (PCP) Status (N = 5,147)

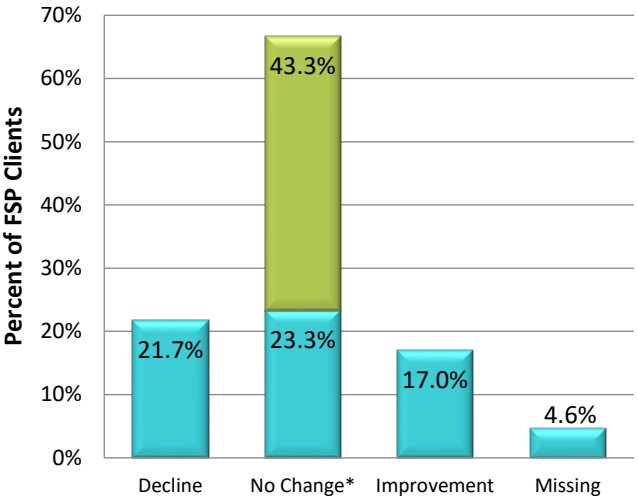
91% of FSP clients had and maintained a PCP.





School Attendance (N = 5,147)

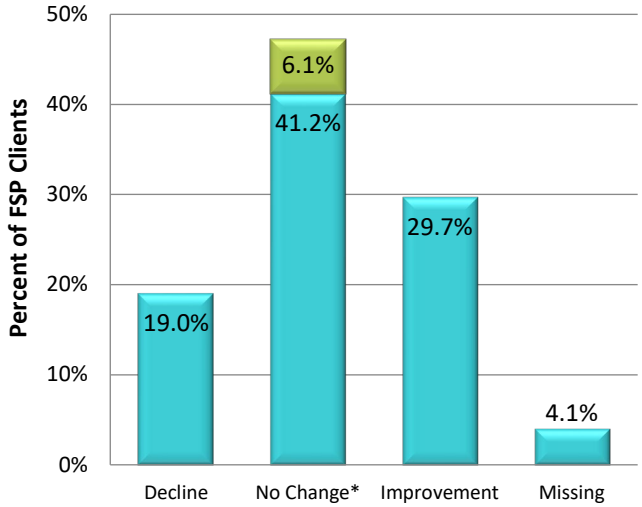
60% of FSP clients either improved (17%) or maintained excellent (43%) school attendance at follow-up assessment as compared to intake.



**Of the 67% of clients for whom no change was noted, 43% (green portion of bar) had consistently excellent attendance (intake and discharge assessments indicated the most positive category for school attendance).*

Academic Performance (N = 5,147)

36% of FSP clients either improved (30%) or maintained excellent (6%) grades at follow-up assessment as compared to intake.



**Of the 47% of clients for whom no change was noted, 6% (green portion of bar) had consistently excellent grades (intake and discharge assessments indicated the most positive category for school grades).*

NOTE: Percentages may not add up to 100% due to rounding.

What Does This Mean?

- Data may be impacted starting March 2020 due to the COVID-19 pandemic.
- Fewer clients were served in the same number of FSP programs in FY 2019-20, as compared to FY 2018-19.
- Children and youth who receive treatment in FSP programs showed improvement in their mental health symptoms and reductions in needs, according to client, parent, and clinician report. The CANS-EC, which was implemented in FY 2019-20, showed reductions in needs between intake and discharge for the majority of young children ages 0-5.
- On average, children and youth who received treatment by SUD counselors showed improvement in their risk for substance abuse problems.
- The majority of youth FSP clients had and maintained a PCP during their participation in FSP programs.
- More than half of youth FSP clients either improved or maintained excellent school attendance during their participation in FSP programs.

Next Steps

- FSP programs should continue to work with schools so that youth FSP clients can improve academic performance.



For more information on *Live Well San Diego*, please visit www.LiveWellSD.org

The Child & Adolescent Services Research Center (CASRC) is a consortium of over 100 investigators and staff from multiple research organizations in San Diego County and Southern California, including: Rady Children's Hospital, University of California San Diego, San Diego State University, University of San Diego, and University of Southern California. The mission of CASRC is to improve publicly funded mental health service delivery and quality of treatment for children and adolescents who have or are at high risk for the development of mental health problems or disorders. For more information please contact Amy Chadwick at aechadwick@health.ucsd.edu or 858-966-7703 x247141.

APPENDIX J

ANNUAL SYSTEM-WIDE ASSERTIVE COMMUNITY TREATMENT (ACT) REPORT FY 2019-20



Making a Difference in the Lives of Adults and Older Adults with Serious Mental Illness

The County of San Diego's Full Service Partnership (FSP) programs use a "whatever it takes" model to comprehensively address individual and family needs, foster strong connections to community resources, and focus on resilience and recovery to help individuals achieve their mental health treatment goals. Targeted to help clients with the most serious mental health needs, FSP services are intensive, highly individualized, and aim to help clients achieve long-lasting success and independence.

Assertive Community Treatment (ACT) programs, which include services from a team of psychiatrists, nurses, mental health professionals, employment and housing specialists, peer specialists, and substance abuse specialists, provide medication management, vocational services, substance abuse services, and other services to help FSP clients sustain the highest level of functioning while remaining in the community. Services are provided to clients in their homes, at their workplace, or in other community settings identified as most beneficial to the individual client. Crisis intervention services are also available to clients 24 hours a day, 7 days a week.

Drawing from multiple data sources, this report presents a system-level overview of service use and recovery-oriented treatment outcomes for those who received FSP services from the 19 ACT programs* in San Diego County during fiscal year (FY) 2019-20.

- Demographic data and information about utilization of inpatient and emergency psychiatric services were obtained from the County of San Diego Cerner Community Behavioral Health (CCBH) data system.
- Information related to:
    1. basic needs, such as housing, employment, education, and access to a primary care physician and
    2. emergency service use and placements in restrictive and acute medical settings

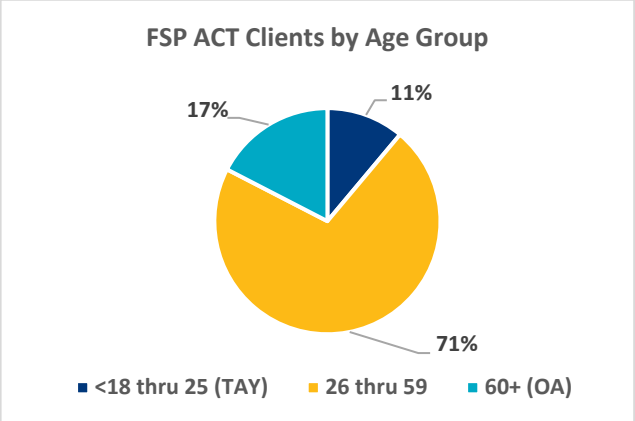
  were retrieved from the Department of Health Care Services (DHCS) Data Collection and Reporting (DCR) system used by FSP programs across the State of California.
- Recovery outcomes and progress toward recovery were obtained from the County of San Diego's Mental Health Outcomes Management System (mHOMS).

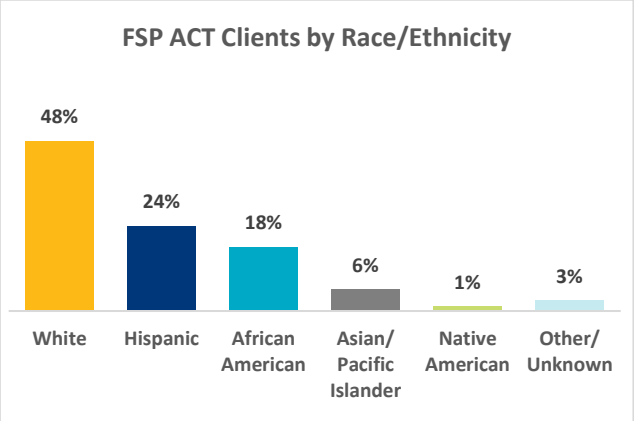
*Data from the following programs are included in this report (program name and sub-unit): CRF Downtown IMPACT (3241, 3244, 3245), Telecare Gateway to Recovery (3312, 3315), Telecare LTC (3331), MHS North Star (3361, 3364), CRF IMPACT (3401, 3404), MHS Center Star (3411, 3413, 3414), CRF Senior IMPACT (3481, 3482), Telecare PROPS AB109 (4192), Telecare MH Collaborative Court (4201, 4203), Telecare Assisted Outpatient Treatment (4211), MHS City Star (4221), MHS Action Central (4242), MHS Action East (4251), Pathways Catalyst (4261, 4264), CRF Adelante (4341), MHS North Coastal (4351), Telecare Vida (4401), Telecare La Luz (4421) and Telecare Tesoro (4411).

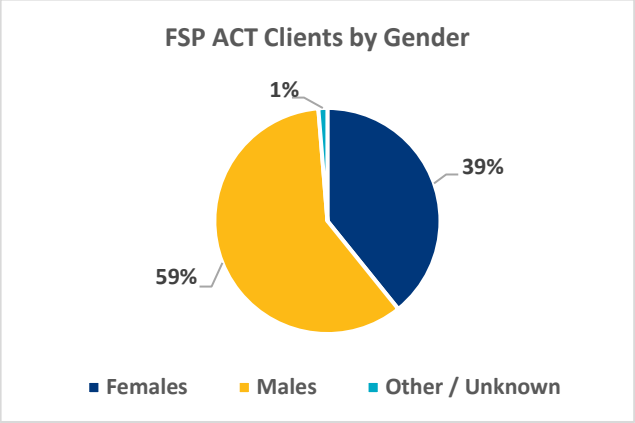
Note: Due to rounding, percentages in this report may not sum to 100%.

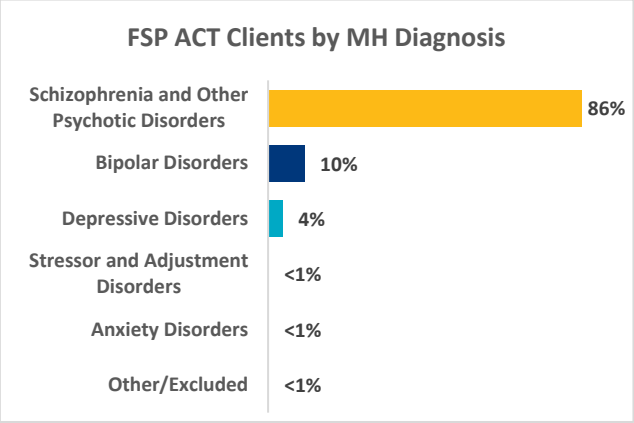
Demographics and Diagnoses

During FY 2019-20, 3,060 FSP clients received services from ACT programs in San Diego County. Of these, most clients were between the ages of 26 and 59 years (71%), a majority were male (59%), and the vast majority had a primary mental health diagnosis of schizophrenia or a psychotic disorder (86%). The next most common primary mental health diagnosis among FSP ACT clients served during the fiscal year was bipolar disorders (10%). In addition to their primary mental health diagnosis, 82% of FSP ACT clients served during FY 2019-20 had a history of substance use disorder. Almost half of FSP clients who received services from ACT programs during this period were White (48%), nearly one-fourth were Hispanic (24%) and approximately one-fifth were African American (18%).

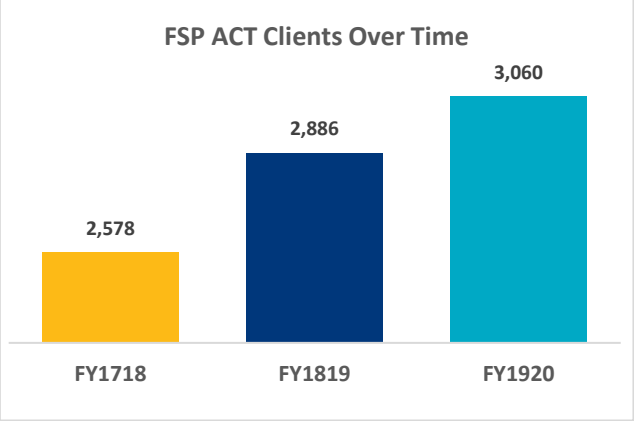








Since FY 2017-18, there have been nearly 500 additional FSP clients served by ACT teams each year. These additional clients reflect a 19% increase in the number of FSP clients served by ACT programs since FY 2017-18. The distribution of the key demographics highlighted above among FSP ACT clients served during FY 2019-20 is similar to the demographics of the clients served by these programs during the previous two fiscal years.



Meeting FSP ACT Clients' Basic Needs*

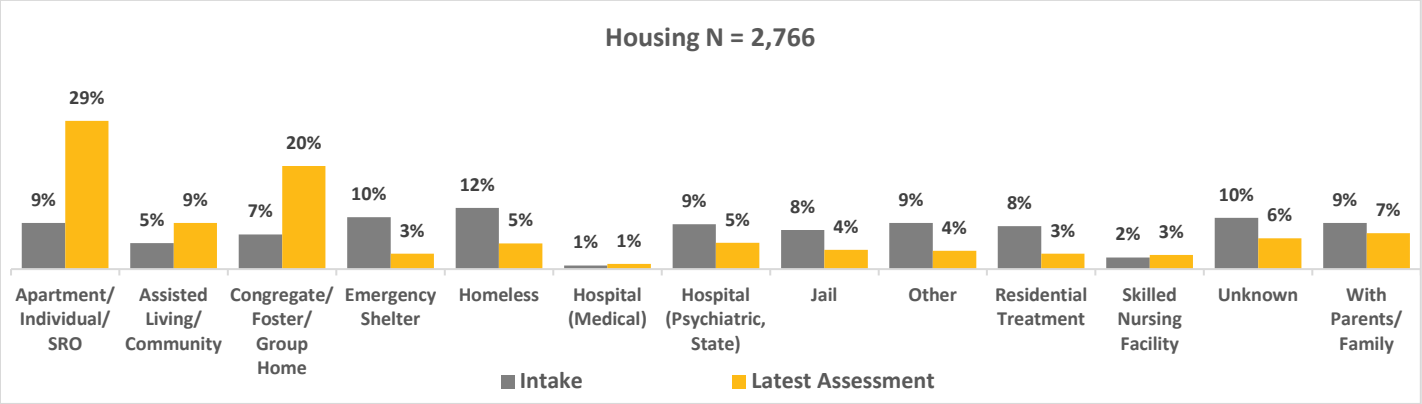
Housing

During FY 2019-20, FSP clients served by ACT programs showed progress in several areas of basic needs. Compared to intake, more than three times as many clients were living in an apartment/individual/single room occupancy (SRO) setting at the time of their latest assessment (9% at intake versus 29% at the latest assessment). Similarly, the proportion of clients living in a congregate, foster, or group home setting almost tripled from intake (7%) to the latest assessment (20%) and the proportion of clients living in an assisted living or community setting nearly doubled from intake (5%) to the latest assessment (9%).

Notable decreases in the proportion of clients living in specific housing settings were also observed from intake to latest assessment. The proportion of clients housed in an emergency shelter decreased from 10% to 3%, the proportion of clients reporting a psychiatric hospital as their residence decreased from 9% to 5%, and the proportion of homeless clients decreased by nearly two-thirds from intake (12%) to latest assessment (5%).

Key Findings: Housing

- The proportion of FSP ACT **clients living in an apartment/individual/single room occupancy** (SRO) setting more than **tripled** from intake (9%) to latest assessment (29%).
- The proportion of **clients** housed in an **emergency shelter decreased** from 10% at intake to 3% at the latest assessment.
- The proportion of **homeless clients decreased** by nearly **two-thirds** from intake (12%) to latest assessment (5%).



Employment

Many FSP clients served by ACT programs are connected to meaningful occupational opportunities as part of their recovery. Depending on individual need, occupational activities can include volunteer work experience, supported employment in sheltered workshops, and/or competitive paid work.

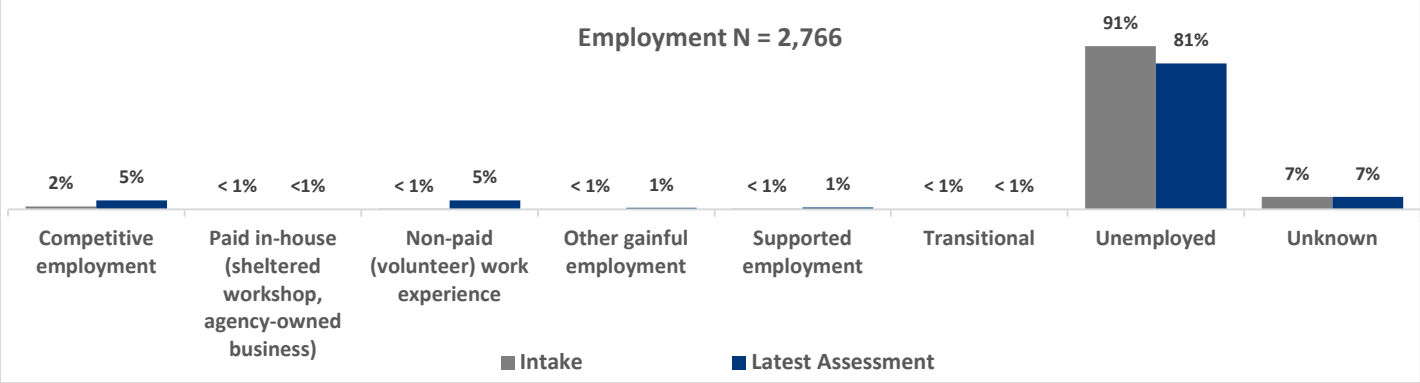
While most clients remained unemployed at the time of the latest assessment (81%), there was a 10% reduction in the number of clients that were unemployed at the latest assessment (2,246 clients) compared to intake (2,508 clients). The most notable increase in employment status from intake to latest assessment was observed among those working in non-paid (volunteer) settings (less than five clients at intake compared to 140 clients at the latest assessment). Additionally, there were roughly three times as many FSP ACT clients employed in competitive settings at the time of the latest assessment (140 clients) compared to the number employed at intake (48 clients). Similarly, there were about four times as many FSP ACT clients working in supported employment settings at the time of the latest assessment (26 clients) compared to intake (6 clients).

*Basic needs data (housing, employment, education, and report of a primary care physician) were compiled from all FSP ACT clients active at any time during FY 2019-20, as of the 12/2020 DHCS DCR download.

Lastly, while less than five clients were employed in another gainful employment setting at intake, 21 clients were employed in this setting at the time of the latest assessment.

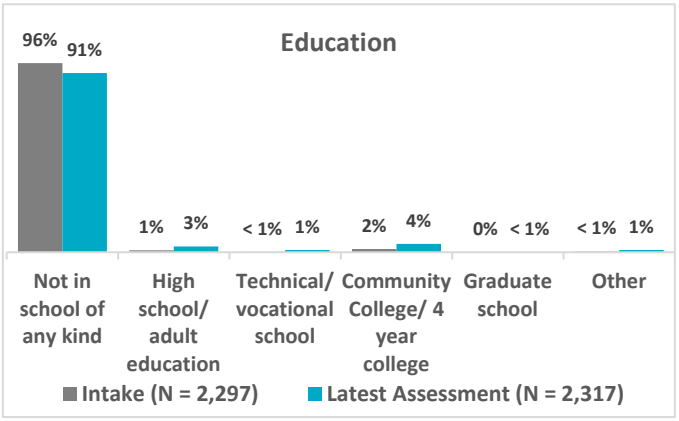
Key Findings: Employment

- There was a 10% **reduction** in the number of clients that were **unemployed** at the latest assessment compared to intake.
- Compared to intake, there were notable **increases** in the number of clients employed in **non-paid** (volunteer), **competitive**, **supported,** and **other gainful** employment settings.



Education

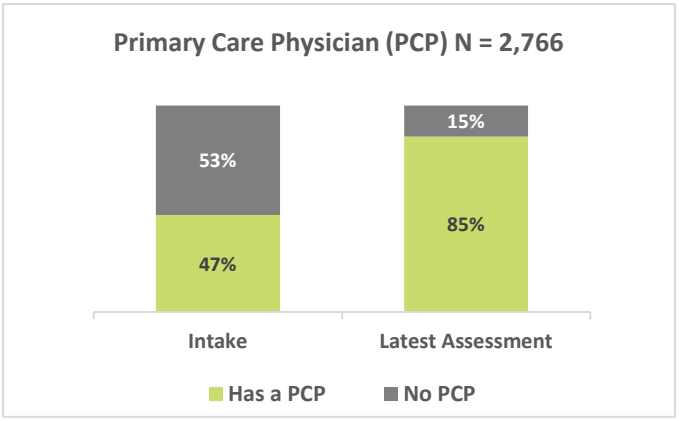
Education is a goal for some FSP clients who receive ACT services, but not all. Of the 2,297 FSP ACT clients with education information available at intake[†], 87 (4%) were enrolled in an educational setting. At the time of the latest assessment, 215 of the 2,317 FSP ACT clients with educational information available (9%) were enrolled in an educational setting[†]. The largest increases from intake to latest assessment were observed in the proportion of clients enrolled in a community or four year college (2% at intake versus 4% at the latest assessment for both settings) compared to other types of educational settings.



Primary Care Physician

Among FSP ACT clients served during FY 2019-20, there was a large increase in the number and proportion of clients who had a primary care physician at the time of the latest assessment compared to intake. Slightly less than half (47%; 1,302 clients) had a primary care physician at intake, while a majority (85%; 2,360 clients) had a primary care physician at the time of their latest assessment.

Overall, changes in basic needs from intake to latest assessment during FY 2019-20 were similar to those observed during previous fiscal years.



[†]Education information was missing for 469 clients at intake, and 449 clients at the time of the latest assessment.

Changes in Service Use and Setting

Use of Inpatient and Emergency Services (Pre/Post)‡

These programs employ a "whatever it takes" model to help clients avoid the need for emergency services such as Crisis Stabilization (CS), Urgent Outpatient (UO), Psychiatric Emergency Response Team (PERT) services, Crisis Residential (CR), and services provided at the psychiatric hospital. Overall, utilization of these types of services decreased by more than half (55%) from pre to post assessment during FY 2019-20. While utilization of all types of emergency services decreased from pre to post assessment, there was a greater reduction in the number of CR and psychiatric hospital services compared to the other types of emergency services (77% and 65%, respectively, compared to reductions of 31% to 40%).

Similar to the reduction in overall emergency service utilization, there was a 48% reduction in the number of unique FSP ACT clients who used emergency services from pre to post assessment with the largest reductions observed among clients receiving CR services (74%) and services at the psychiatric hospital (57%). The number of clients who received a PERT service decreased by 39% from pre to post assessment and the number of clients who received a CS or a UO service decreased by 39% and 34%, respectively, from pre to post assessment. A reduction in the overall mean number of emergency services per client was also observed from pre to post assessment (12%) with the most notable reductions observed among those receiving services from the CR (13%) and psychiatric hospital LOCs (18%).

Reductions in utilization of PERT, CR, and psychiatric hospitalization services among FSP ACT clients during FY 2019-20 were similar to reductions in utilization observed among this population during FY 2017-18 and FY 2018-19. CS and CO services were new levels of care that were introduced in FY 2015-16, and there was an expected initial increase in utilization of these services during FY 2016-17 and FY 2017-18. CO was renamed to UO in FY 2018-19 to more accurately reflect the types of services provided at that level of care.

Key Findings: Use of Inpatient and Emergency Services

- Utilization of **all emergency services decreased** among FSP ACT clients from pre to post assessment.
- The **greatest reductions** in emergency service utilization were observed in the **CR** and **psychiatric hospital** LOCs.
- The mean number of **UO, PERT,** and **CS** services per client **remained relatively stable** among FSP ACT clients from pre to post assessment.

	# OF SERVICES			# OF CLIENTS*			MEAN # OF SERVICES PER CLIENT		
Type of Emergency Service	Pre	Post	% Change	Pre	Post	% Change	Pre	Post	% Change**
CS	521	337	-35%	259	158	-39%	2.01	2.13	6%
UO†	572	393	-31%	285	188	-34%	2.01	2.09	4%
PERT	701	419	-40%	410	251	-39%	1.71	1.67	-2%
Crisis Residential	728	164	-77%	401	104	-74%	1.82	1.58	-13%
Psychiatric Hospital	1,645	580	-65%	622	269	-57%	2.64	2.16	-18%
Overall	**4,167**	**1,893**	**-55%**	**861**	**444**	**-48%**	**4.84**	**4.26**	**-12%**

**The overall number of clients at Pre (n=861) and Post (n=444) represent unique clients, many of whom used multiple, various services, while some clients did not use any emergency services.*

***Percent change is calculated using the pre and post means.*

Note: Clients in this analysis (n=1,377) had an enrollment date ≤ 7/1/2019 and discontinued date (if inactive) > 7/1/2019. Data may include individuals discharged from FSP during the fiscal year but who continued to receive services from a different entity.

†Formerly Crisis Outpatient (CO)

‡Pre period data encompasses the 12-months prior to each client's FSP enrollment and are sourced from the 10/2019 CCBH download. The 12/2020 DHCS DCR download was used to identify active clients, and for Post period data.

Placements in Restrictive and Acute Medical Settings (Pre/Post)[§]

Similar to previous fiscal years, there were overall decreases from pre to post assessment in the mean number of days spent (60% reduction), and number of FSP ACT clients (58% reduction) residing in the following restrictive settings: jail/prison, state psychiatric hospital, and long-term care. The largest reductions observed from pre to post assessment were in the number of days clients spent in a state hospital (84% reduction) and the number of clients who resided in a state hospital (82% reduction). Notable reductions were also observed in the number of days (65% reduction) and the number of clients (57% reduction) residing in long-term care settings from pre to post assessment.

The residential status of individuals receiving FSP services is changed to "Acute Medical Hospital" when admission to a medical hospital setting occurs for a physical health reason such as surgery, pregnancy/birth, cancer, or another illness requiring hospital-based medical care. Data pertaining to placements in acute medical care settings are reported separately in the table below. Compared to pre assessment, there was nearly over a one and a quarter times increase (122%) in the number of days FSP ACT clients spent in an acute medical hospital setting, and a 29% increase in the number of FSP ACT clients in an acute medical hospital setting at post assessment. It is possible that this increase may be partly facilitated by the ACT programs as FSP ACT clients may have delayed seeking necessary medical care during crises prior to enrollment in an ACT program.

In general, during FY 2019-20 the rates of change between pre and post assessment for each type of restrictive setting mirrored the rates observed for these settings during the previous fiscal year. One change from last fiscal year is that the mean number of days per FSP ACT client in the state hospital decreased by 8% from pre to post during FY 2019-20 but increased by 32% during FY 2018-19. This phenomenon can be explained by the fact that during FY 2019-20 the number of FSP ACT clients residing in a state hospital increased by a greater proportion from pre to post than the total number of days clients spent in a state hospital. During FY 2018-19, the opposite was true. Also to note, is the observed 23% increase in the mean number of days per client spent in a jail or prison setting, a trend consistent with the increase observed during FY 2018-19.

Key Findings: Placements in Restrictive and Acute Medical Settings

- Placements in restrictive settings such as **jail/prison,** the **state hospital**, and **long-term care** settings **decreased** among FSP ACT clients from pre to post assessment.
- Placements in **acute medical hospital** settings **increased** among FSP ACT clients from pre to post assessment.
- The mean number of days per client in the **acute medical hospital**, and **jail/prison** settings **increased** from pre to post assessment while the mean number of days per client in **long-term care,** and **state hospital** settings **decreased**.

	# OF DAYS			# OF CLIENTS*			MEAN # OF DAYS PER CLIENT		
Type of setting	Pre	Post	% Change	Pre	Post	% Change	Pre	Post	% Change**
Jail/Prison	38,897	21,061	-46%	385	169	-56%	101.03	124.62	23%
State Hospital	9,172	1,477	-84%	57	10	-82%	160.91	147.70	-8%
Long-Term Care	69,587	24,030	-65%	249	106	-57%	279.47	226.70	-19%
Overall	**117,656**	**46,568**	**-60%**	**646**	**274**	**-58%**	**182.13**	**169.96**	**-7%**
Acute Medical Hospital	4,202	9,336	122%	182	234	29%	23.09	39.90	73%

**The overall number of clients at Pre (n=646) and Post (n=274) represent unique clients who may have been placed in multiple and/or various types of settings.*

***Percent change is calculated using the pre and post means.*

[§]Data source: DHCS DCR 12/2020 download; 12-month pre-enrollment DCR data rely on client self-report.

Measuring Progress Towards Recovery**

Overall Assessment Means for Assessments 1 and 2

FSP ACT clients' progress toward recovery is measured by two different instruments:

- **Illness Management and Recovery Scale** (IMR), &
- **Recovery Markers Questionnaire** (RMQ).

Clinicians use the IMR scale to rate their clients' progress towards recovery, including the impact of substance use on functioning. The IMR is comprised of 15 individually scored items, and assessment scores can also be reported as an overall score or by three subscale scores:

- Progress towards recovery (**Recovery**),
- Management of symptoms (**Management**), and
- Impairment of functioning through substance use (**Substance**).

Clients can use the 24-item self-rated RMQ tool to rate their own progress towards recovery. Mean IMR and RMQ scores range from 1 to 5, with higher ratings on both assessments indicative of greater recovery.

The IMR and RMQ scores displayed in the charts to the right compare scores of New FSP ACT clients to those of All FSP ACT clients.

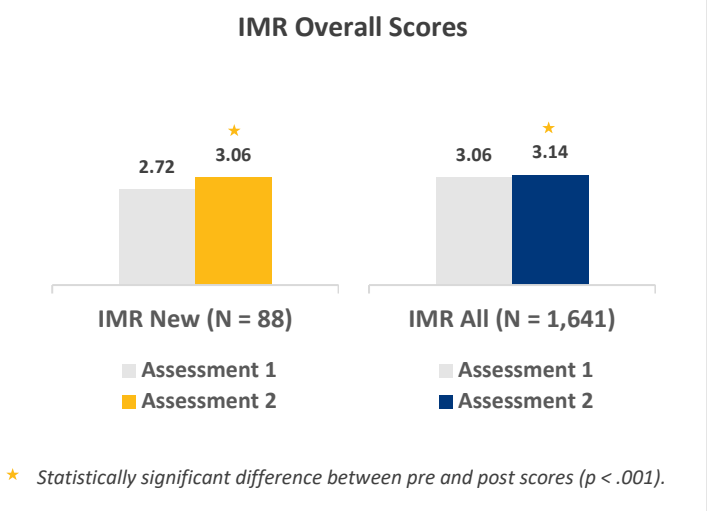
- **New** clients are defined as those who:
  1. began receiving ACT services in 2019 or later,
  2. had two IMR or RMQ assessments during FY 2019-20 (assessments 1 and 2), and
  3. had a first service date within 30 days of their first IMR assessment.
- **All** clients include every FSP ACT client with at least two IMR or RMQ assessments during FY 2019-20 (assessments 1 and 2), regardless of the length of FSP services from ACT programs.

Clients receiving FSP services from ACT programs are generally reassessed on these IMR and RMQ measures every six months to measure progress towards recovery. In general, assessment scores for New clients tend to more directly demonstrate the effect of FSP ACT services on client outcomes because All clients include individuals who may have received services for many years.

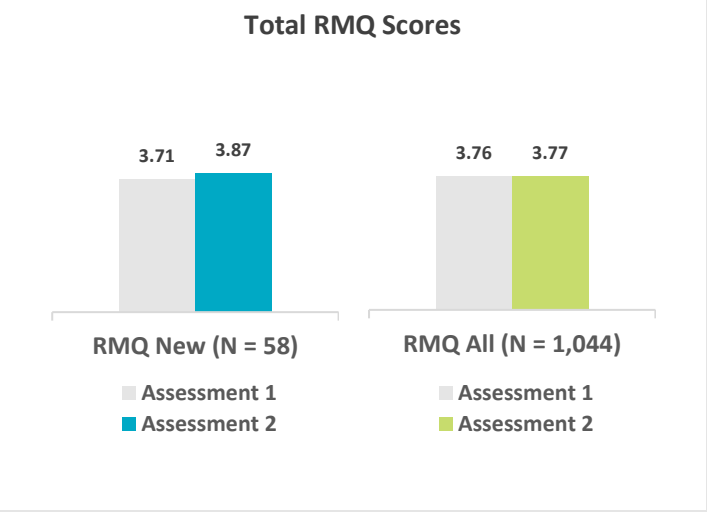
As expected, overall IMR and RMQ assessment 1 mean scores for New clients were lower than assessment 1 mean scores for All clients. For both groups overall IMR assessment 2 mean scores were significantly higher than overall IMR assessment 1 mean scores ($p < .001$).

The mean assessment 1 score from All clients was relatively high compared to mean scores among New clients, suggesting that clients enrolled in ACT services for a longer period of time may have reached a point in their recovery where they are maintaining their current recovery and improvement is no longer expected.

Overall RMQ mean scores were slightly higher at assessment 2, compared to assessment 1 for both New and All clients, but this increase did not reach statistical significance for either group of clients. RMQ assessment scores for New and All clients were higher than their IMR scores indicating that both groups of clients rated their progress higher than clinicians did.



★ *Statistically significant difference between pre and post scores ($p < .001$).*



** Outcomes data are sourced from mHOMS FY 2019-20; Data include all mHOMS entries as of 3/10/2021 for clients who received services in FSP ACT programs, completed an IMR or RMQ assessment 2 during FY 2019-20, and who had paired IMR or RMQ assessments 4 to 8 months apart.

IMR Subscale Means for Assessments 1 and 2

Changes in mean scores on each of the three IMR subscales from assessment 1 to assessment 2 were also analyzed for each group of clients (New and All). On average, both New and All FSP ACT clients had significantly higher mean Recovery and Management subscale scores ($p < .001$) at assessment 2 than they did at assessment 1. These data suggest that New and All clients made significant progress towards recovery and were better able to manage their symptoms and maintain their recovery from assessment 1 to assessment 2.

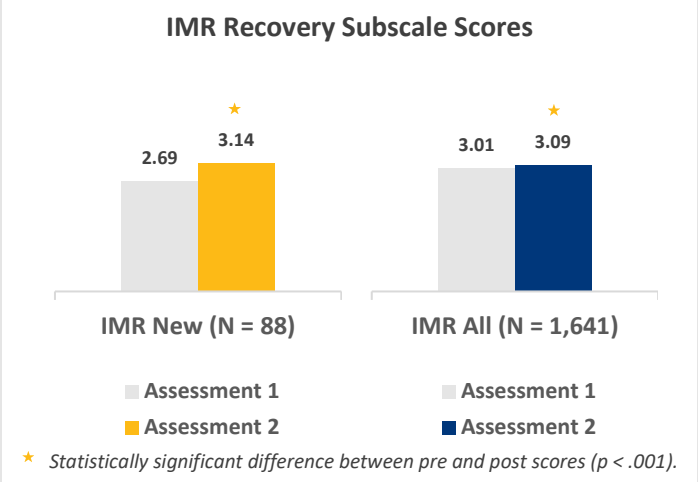
Two questions on the IMR assessment asked clinicians to rate the degree in which alcohol and/or drug use impaired the functioning of their client. Substance Use subscale scores at assessment 1 were high for both New and All clients, suggesting that the majority of FSP ACT clients may experience low or minimal impairment in functioning due to drug or alcohol use as a higher rating is indicative of greater recovery.

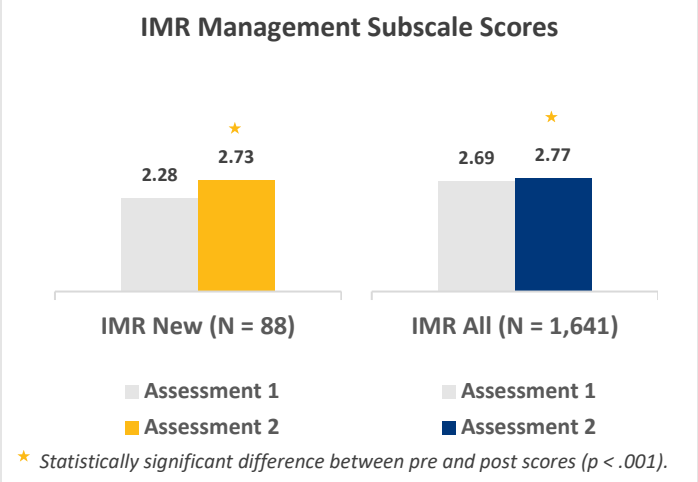
The All FSP ACT clients had slightly higher mean Substance Use scores at assessment 2 compared to assessment 1, however this difference in mean scores was not statistically significant.

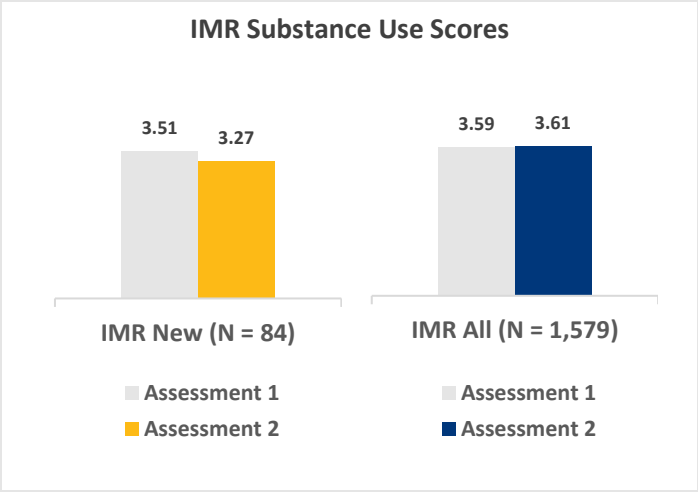
Key Findings: Assessment Outcomes

- Mean **Overall IMR** scores were **significantly higher** at the latest assessment compared to the first assessment for **New and All** clients.
- Mean **Recovery** and **Management** subscale scores were **significantly higher** at the latest assessment compared to the first assessment for both **New and All** clients.
- Mean **Substance Use** subscale scores were **significantly lower** at assessment 2 compared to the assessment 1 for **New** clients.
- Mean **Substance Use** subscale scores were **slightly higher** at assessment 2 compared to the assessment 1 for **All** clients.
- **Overall RMQ** scores were **not statistically significant** between assessments for both **New and All** clients.
- RMQ ratings suggest that both **New** and **All** clients rated their progress higher than clinicians did.

These findings suggest that drug and alcohol use may be a factor in impairment of functioning among FSP clients new to ACT services but may not be a primary focus of early treatment, and may be an area addressed after these clients are in services for a while.

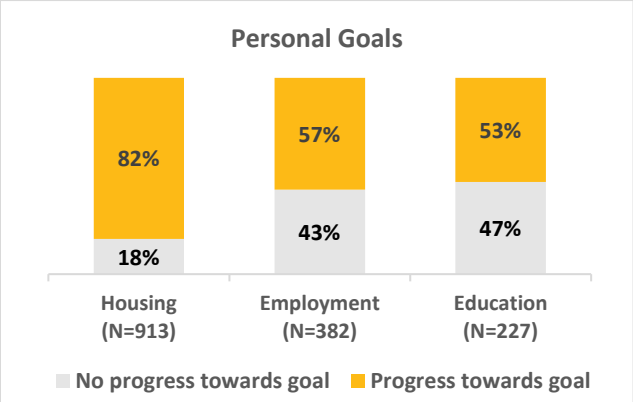






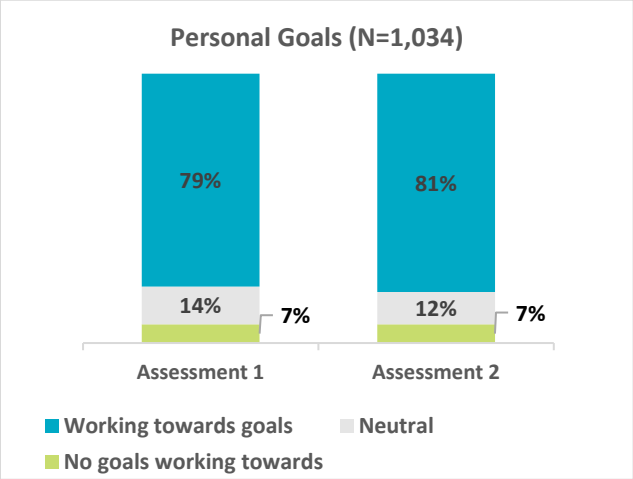
Progress Towards Key Treatment Goals

At the time of their follow-up IMR assessments, clinicians also noted client progress towards goals related to housing, education, and employment. Similar to trends observed during FY 2018-19, most FSP ACT Clients served during FY 2019-20 with a completed Goal assessment had a goal related to housing (913 clients; 88%) on their treatment plan. Of these clients, clinicians reported that 82% made progress towards their individual housing goal at the time of the latest assessment. Fewer FSP ACT clients had goals related to employment (382 clients; 37%) or education (227 clients; 22%) on their treatment plan, compared to the number with housing related goals. Additionally, over one-half of clients with goals related to employment or education made progress towards their goals at the time of the most recent assessment (57% and 53%, respectively). These results may reflect a "housing first" approach in that obtainment of stable housing may be a primary focus for most FSP ACT clients, while goals related to employment and education may be secondary and an area of focus after stable housing is obtained.



Personal Goals

One of the items in the RMQ assessment asks clients if they have goals which they are working towards achieving. More than three-quarters of FSP ACT clients at assessment 1 (79%) and assessment 2 (81%) agreed or strongly agreed that they had a goal (or goals) they were working towards. At assessment 1, 14% of clients reported they were "neutral" about working towards goals, compared to 12% at assessment 2. Only 68 FSP ACT clients (7%) disagreed or strongly disagreed with the statement that they were working towards achieving goals at the time of the latest assessment. Responses to this RMQ item were unavailable for ten clients at both assessments. Figures reported in the chart to the right exclude these clients from percentage calculations.



Level of Care

Completed by clinicians, the Level of Care Utilization System (LOCUS) is a short assessment of a client's current level of care needs and provides a system for assessment of service need for adults. The LOCUS is based on the following six evaluation parameters:

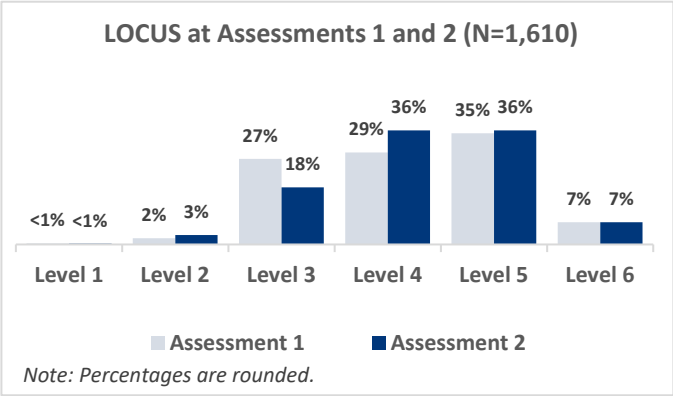
1. risk of harm,
2. functional status,
3. medical, addictive, and psychiatric co-morbidity,
4. recovery environment,
5. treatment and recovery history, and
6. engagement and recovery status.

In the LOCUS, levels of care are viewed as levels of resource intensity. Lower numbered levels correspond with lower intensity resources and services.

LOCUS Resource Levels

	Level of Care Description
Level 1	Recovery maintenance and health maintenance
Level 2	Low intensity community-based services
Level 3	High intensity community-based services
Level 4	Medically monitored non-residential services
Level 5	Medically monitored residential services
Level 6	Medically managed residential services

Similar to LOCUS results from previous fiscal years, the greatest proportion of FSP ACT clients were recommended for medically monitored non-residential services (Level 4) and medically monitored residential services (Level 5) by clinicians at both assessments. A large reduction in the proportion of clients recommended for high intensity community-based services (Level 3) was observed from assessment 1 to assessment 2, and a similar proportion of clients recommended for medically managed residential services (Level 6) was observed between assessments.



Note: Percentages are rounded.

Key Findings: Goals and LOCUS

- **Most** FSP ACT clients (88%) had a **housing related goal** on their treatment plan.
- Of the clients with a housing goal on their treatment plan, a **majority** (82%) **made progress** towards that goal by assessment 2.
- **Most** clients (81%) agreed or strongly agreed that they were **working towards a treatment goal** at assessment 2.
- Clients were most likely to be recommended for a **Level 4** or **Level 5** treatment setting at both times points.

Conclusion

With the addition of several new FSP ACT programs within the San Diego County Behavioral Health System of Care during the past few years, there has been increased interest in learning more about the impact of these programs on clients' service use and outcomes. The FSP ACT model aims to serve homeless clients with severe mental illness, as evidenced by the vast majority of clients served during FY 2019-20 with 1) a housing-related goal (88%), 2) a diagnosis of schizophrenia or psychotic disorder (86%), or 3) a recommendation for medically monitored or managed treatment services (LOCUS Levels 4 through 6; 71% at intake).

Similar to trends reported from previous fiscal years, FSP ACT clients served during FY 2019-20 showed progress in the following areas of basic needs: housing, employment, and having a primary care physician. Notably, the proportion of clients living in an apartment/individual/ single room occupancy setting tripled from intake (9%) to latest assessment (29%), the proportion housed in an emergency shelter decreased from 10% at intake to 3% at the latest assessment, and the proportion of homeless clients decreased from 12% at intake to 5% at the latest assessment. There was also a 10% reduction in the number of clients unemployed at the latest assessment compared to intake and an 37% increase in the number of clients with a primary care physician at the time of the latest assessment, compared to intake.

Additional success of the FSP ACT model is evident from reductions observed in 1) utilization of inpatient and emergency services, and 2) placements in restrictive settings among clients. For example, overall, utilization of inpatient and emergency services decreased by 55% compared to utilization rates prior to receipt of services from ACT programs. Similarly, placements in restrictive settings, such as jail/prison, state hospital, and long-term care settings, were also reduced from intake to latest assessment, as measured by the number of days FSP ACT clients spent in these settings (60% reduction), and the number of clients housed in these types of settings (58% reduction). Progress towards recovery among FSP ACT clients was also exhibited by 1) significant improvements in clinician-rated IMR scores for New FSP ACT clients and 2) progress towards treatment plan goals for All ACT clients between two assessment time points.

Overall, improvements were observed in several key areas among FSP clients served by ACT programs during FY 2019-20, mirroring improvements observed among this population during previous fiscal years and demonstrating a positive effect of services on the lives of clients served by the ACT programs.

APPENDIX K

HOUSING UPDATE
EXECUTIVE SUMMARY

County of San Diego
Health and Human Services Agency
Adult/Older Adult Behavioral Health Services

Behavioral Health
Strategic Housing Plan

Updated: November 2020

Executive Summary

Housing is a critical resource for achieving health and wellness, particularly for people with limited means who struggle with behavioral health issues. This Behavioral Health Strategic Housing Plan, as updated, provides a framework for current housing needs and outlines the planning process for the implementation of the Plan's Goals that maximize housing options for people with behavioral health issues in San Diego County.

The initial Plan was finalized in 2014 and included a robust stakeholder process that included input from consumers, service providers, housing developers and operators, and funders of housing and services. Annual updates to the Plan include policy, legislative and financial resource updates, as well as updated feedback from consumers in the form of Housing Council discussions, focus groups with clients, stakeholder check-ins and surveys. During the 30-day Public Review of the Draft Plan initiated in December 2020, additional stakeholder feedback was received and incorporated into the final Plan document (stakeholder input is included in the appendices).

Throughout the Plan, we analyze the importance of housing in achieving recovery, while mapping out local housing needs as well as the resources and tools available to meet those needs. The Plan also specifically recognizes the importance of the Mental Health Services Act (MHSA) in transforming the range of housing and services options to those who were previously unserved or under-served in our communities, as well as recognizing the significant accomplishments in meeting present goals. The specific Plan Goals, as identified in the original Behavioral Health Strategic Housing Plan are to:

1. Expand Inventory of Affordable and Supportive Housing
2. Increase Access to Independent Living Options
3. Provide Opportunities to "Move On" To More Independent Housing Options
4. Expand Opportunities to Increase Income (Employment and Benefits)
5. Lessen Isolation and Keep People Connected to Their Communities
6. Develop Improved Data Collection and Analysis Capacity

The Plan then defines the key strategies and activities that have been implemented to achieve these goals as well as the process to be used to evaluate and update the Plan on an annual basis, creating a living document that reflects and responds to the changing housing and services environment in San Diego from year to year.

This update includes current information regarding a variety of housing and services options for people with behavioral health issues in San Diego County. In particular, this Plan update outlines progress on the opportunity to create significant new supportive housing options under the No Place Like Home initiative. This document also provides narrative related to COVID-19 and its unprecedented potential detrimental impacts on the behavioral health system, as well as the development and/or operation of affordable and supportive housing. The COVID-19 pandemic creates an opportunity for discussion and consideration of housing policy changes that may be needed to keep vulnerable populations healthy and safe in the future by mitigating the harm caused by intense economic disruption resulting from the urgent public health crisis. Housing policy directly impacts health and well-being, and this Plan update outlines the importance of enhancing our current ability to serve our most vulnerable populations in more effective and efficient ways as we respond to the COVID-19 crisis.

APPENDIX L

PREVENTION AND EARLY INTERVENTION (PEI) SYSTEM-WIDE SUMMARY

CHILD & ADULT PEI PROGRAMS

SYSTEMWIDE SUMMARY

COUNTY OF SAN DIEGO HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2019—20 ANNUAL REPORT

The Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funding gives counties a unique opportunity to implement programs to help prevent the onset of mental illness or to provide early intervention to decrease severity. With this funding source, the County of San Diego contracted with providers for PEI programs for adults and older adults, and youth and transition age youth (TAY) and their families. The focus of these programs varies widely, from reducing the stigma associated with mental illness to preventing youth suicide. Each contractor collects information on the demographics of their participants and their satisfaction with the services provided for both active and outreach participants. Active participants include people who are enrolled in a PEI program and/or are receiving services at a PEI program. Outreach participants include people who are touched by the program via outreach efforts, including but not limited to: presentations, community events, and fairs.

DATA: Child and Adult PEI Programs

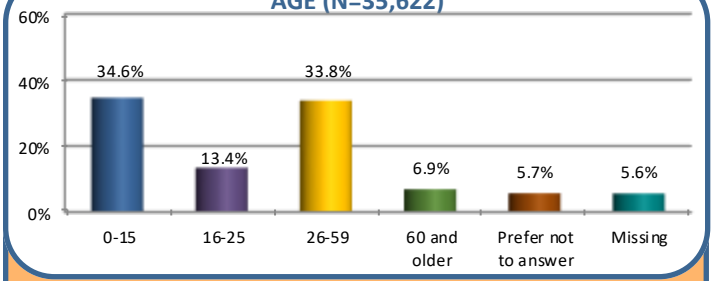
REPORT PERIOD: 7/1/2019-6/30/2020

NUMBER OF PARTICIPANTS WITH DATA IN FY 2019-20: 35,622 (Unduplicated)*†‡

**Data for all students participating in the HERE Now Suicide Prevention program were calculated from a representative sample of students who provided demographic and satisfaction information.*
†Data collection requirements vary by program type. Not all programs are required to collect data for every indicator, which accounts for the two different denominators presented in this report: (N=35,622 vs. N=22,130.
‡All known duplicates are excluded from this count; however, unduplicated status cannot be verified among programs that do not issue client identification numbers.

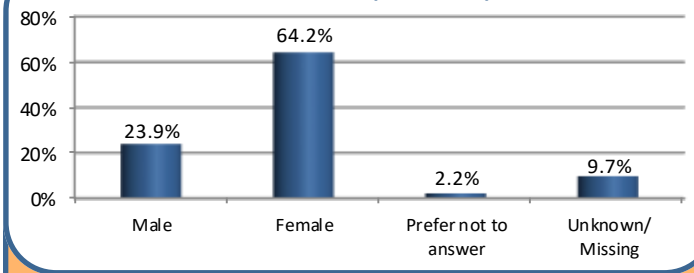
PARTICIPANT SYSTEMWIDE DEMOGRAPHICS

AGE (N=35,622)



Thirty-five percent of participants were under the age of 16, and thirty-four percent were between the ages of 26-59.

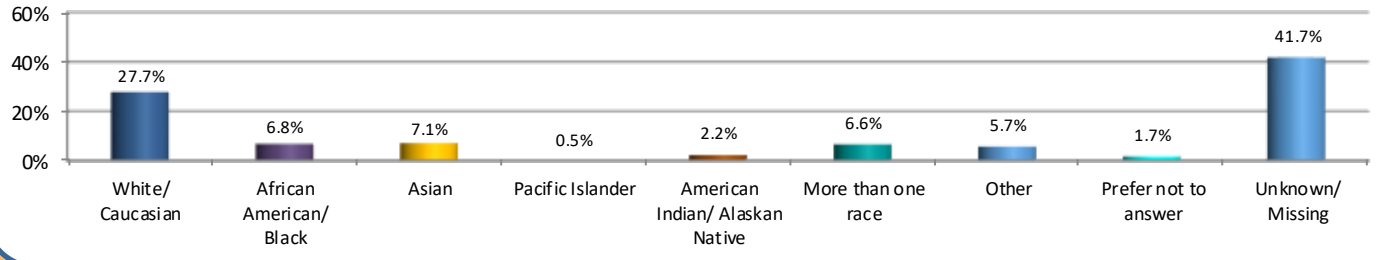
SEX AT BIRTH (N=22,130)*



Sixty-four percent of participants identified their sex at birth as female.

** Not all programs are required to collect data for every indicator, which accounts for the lower denominator (N=22,130 vs N=35,622).*

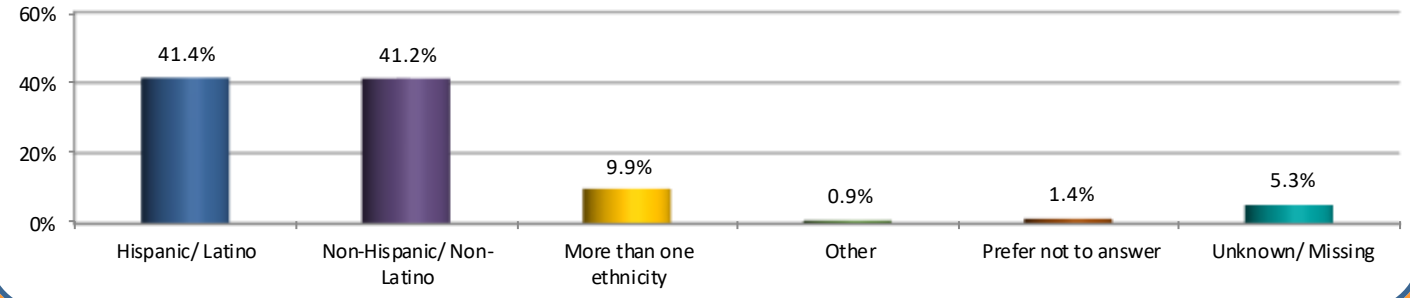
RACE (N=35,622)



Twenty-eight percent of participants identified their racial background as White/Caucasian. Seven percent of participants identified as Asian and nearly seven percent identified as having more than one racial background. The percentage of unknown/missing includes clients who only endorsed being Hispanic/Latino and did not indicate a racial category.

PARTICIPANT SYSTEMWIDE DEMOGRAPHICS

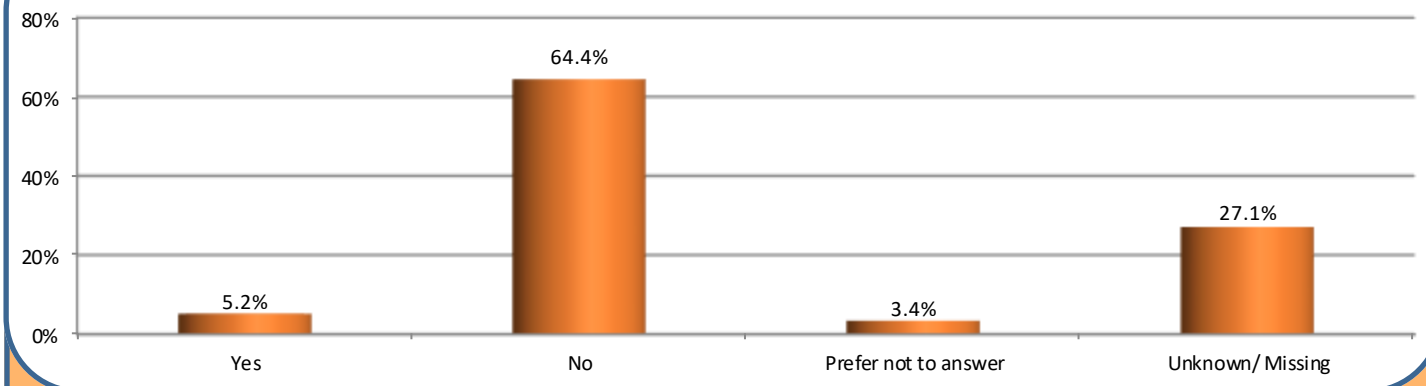
ETHNICITY (N=35,622)



Forty-one percent of participants identified their ethnic background as Hispanic/Latino. Equally, forty-one percent of participants identified their ethnic background as non-Hispanic/non-Latino.

MILITARY SERVICE

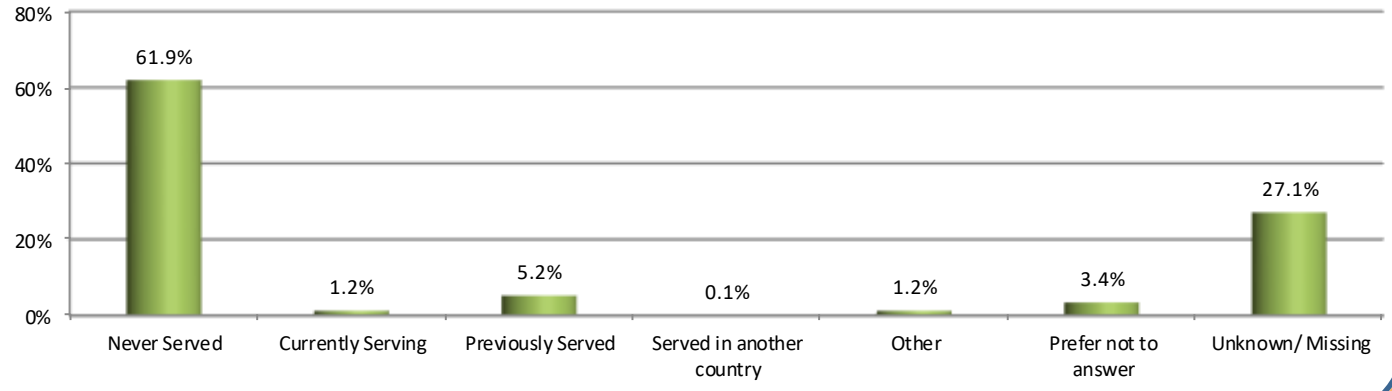
VETERAN STATUS (N=22,130)*



Information on veteran status indicated over five percent of participants had served in the military.

** Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=22,130 vs N=35,622).*

MILITARY STATUS (N=22,130)*

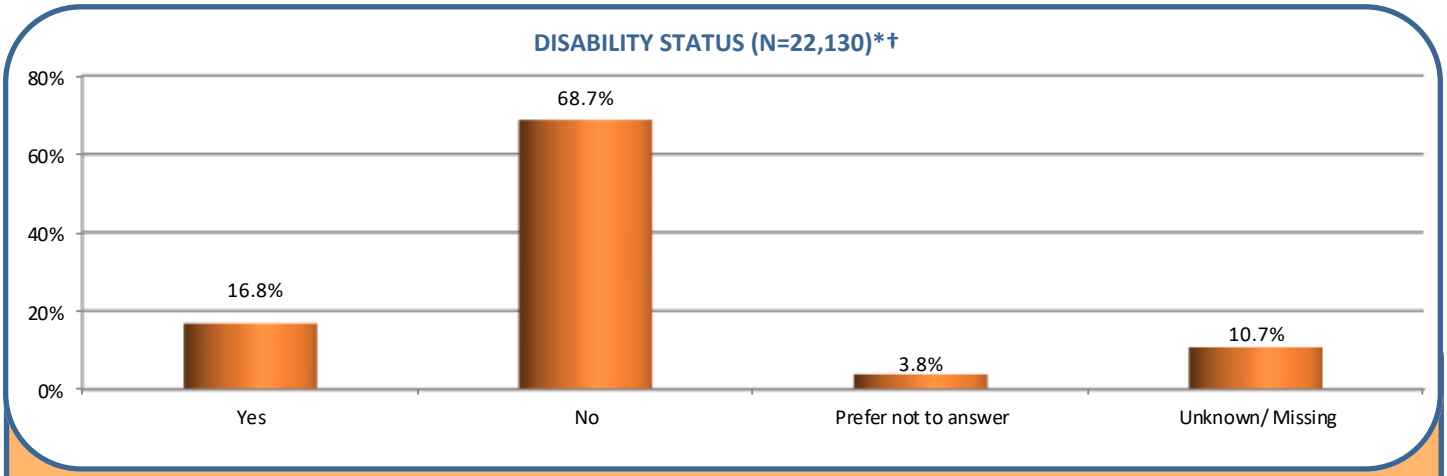


Nearly sixty-two percent of participants had never served in the military. One percent of participants indicated they are currently serving in the military and over five percent indicated they had previously served in the military.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=22,130 vs N=35,622).*

PARTICIPANT SYSTEMWIDE DEMOGRAPHICS - CONTINUED

DISABILITY STATUS



Nearly seventeen percent of participants reported having a disability. Four percent of participants preferred to not answer this question.

**A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness.*

†Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=21,064 vs N=41,164).

DISABILITY (N=22,130)*†‡	Count	%
Difficulty seeing	816	3.7
Difficulty hearing or having speech understood	399	1.8
Mental disability not including mental illness	816	3.7
Learning disability	380	1.7
Developmental disability	123	0.6
Physical/ mobility disability	821	3.7
Chronic health condition/ chronic pain	1,476	6.7
Dementia	78	0.4
Other communication disability	112	0.5
Other mental disability not related to mental illness	235	1.1
Other disability	660	3.0
No disability	15,236	68.8
Prefer not to answer	831	3.8
Unknown/ Missing	2,377	10.7

Sixty-nine percent of the participants indicated no disability. Nearly seven percent of participants indicated having a chronic health/chronic pain condition. Approximately four percent of participants each indicated having a physical/ mobility disability, a mental disability not including mental illness, or difficulty seeing.

**The sum of the percentages may exceed 100% because participants can select more than one type of disability .*

†A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness.

‡Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=22,130 vs N=35,622).

PARTICIPANT SYSTEMWIDE DEMOGRAPHICS - CONTINUED

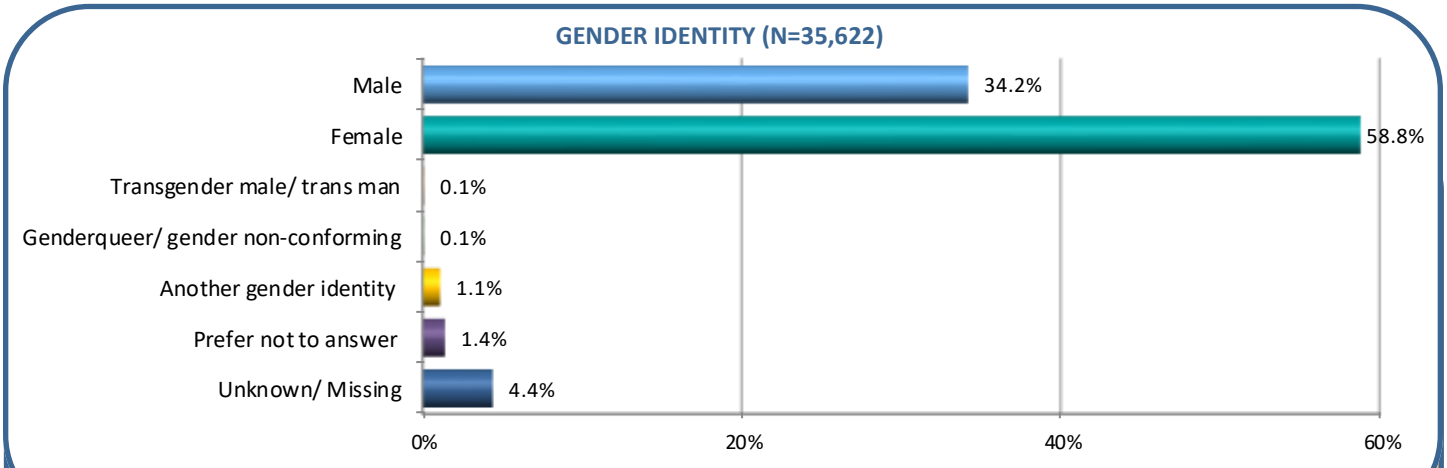
PARTICIPANT LANGUAGE

PRIMARY LANGUAGE (N=22,130)*	N	%
English	10,392	47.0
Spanish	7,565	34.2
American Sign Language	34	0.2
Arabic	644	2.9
Armenian	17	0.1
Cantonese	17	0.1
Farsi	93	0.4
Hebrew	12	0.1
Japanese	14	0.1
Korean	14	0.1
Mandarin	21	0.1
Portuguese	19	0.1
Tagalog	250	1.1
Vietnamese	77	0.3
Other	785	3.5
Prefer not to answer	291	1.3
Unknown/Missing	1,885	8.5

Forty-seven percent of participants identified their primary language as English. Thirty-four percent of participants identified their primary language as Spanish.

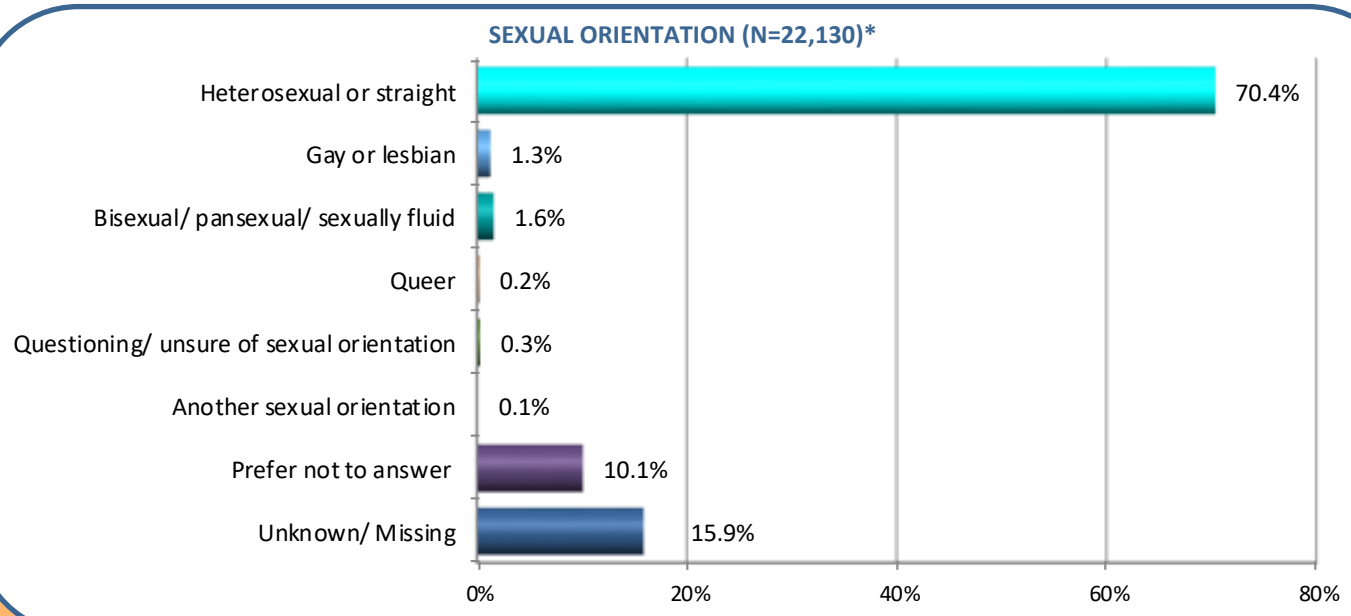
** Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N= 22,130 vs N=35,622).*

GENDER IDENTITY



Fifty-nine percent of the participants identified as female. Thirty-four percent of participants identified as male.

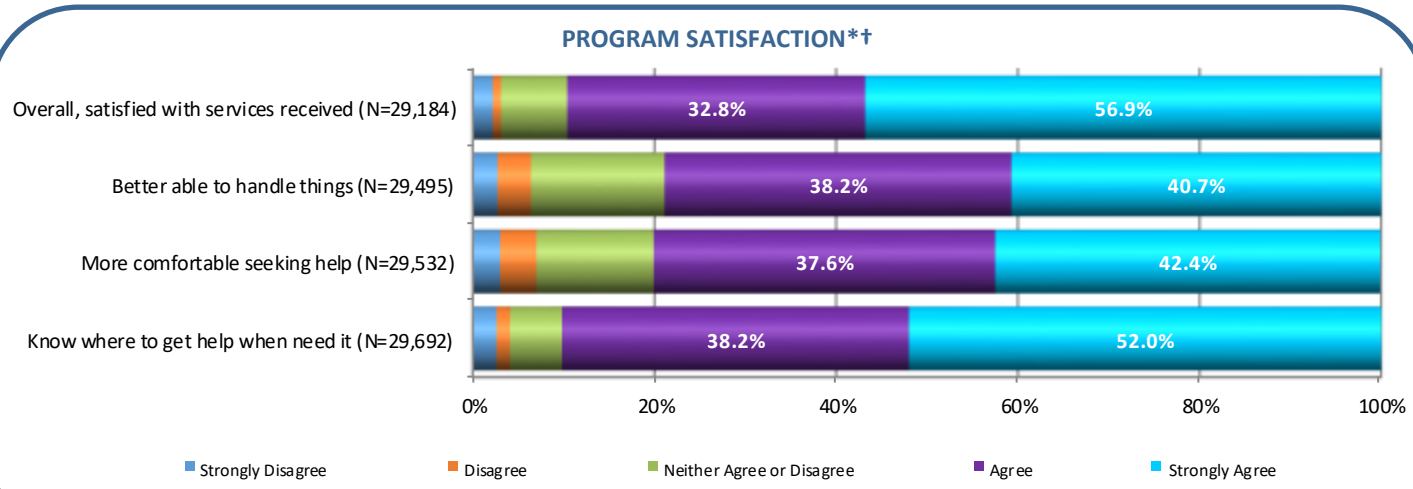
PARTICIPANT SYSTEMWIDE DEMOGRAPHICS - CONTINUED



Seventy percent of the participants identified their sexual orientation as heterosexual/straight. Approximately three percent of participants identified their sexual orientation as bisexual/pansexual/sexually fluid, or gay or lesbian. Ten percent of participants preferred not to answer this question.

** Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=22,130 vs N=35,622).*

PARTICIPANT SYSTEMWIDE PROGRAM SATISFACTION



Ninety percent of the participants agreed or strongly agreed that they knew where to get needed help as a result of the program. Nearly ninety percent of participants agreed or strongly agreed that they were overall satisfied with the services they received. Eighty percent of participants agreed or strongly agreed that they were more comfortable seeking help as a result of the program. An additional seventy-nine percent of participants agreed or strongly agreed that they were better able to handle things and solve problems as a result of the program.

**Satisfaction data not available for all participants.*

†Satisfaction data may include duplicate participants.

CHILD AND ADULT PARTICIPANT SYSTEMWIDE REFERRAL TRACKING SUMMARY

In FY 2016-17, County of San Diego Behavioral Health Services (BHS) implemented a referral tracking procedure in order to collect data on referrals made by PEI programs and successful links to services.

In FY 2019-20, a total of 678 participants received a mental health referral, and 246 of these participants successfully received a mental health service as a result of the referral (Linkage Rate = 36.3%).

A total of 231 participants received a substance use referral, and 112 of these participants successfully received a substance use service as a result of the referral (Linkage Rate = 48.5%).

The average time between referral and linkage to services was seventeen days.

**Referral data were not available for all programs.*

The Health Services Research Center (HSRC) at University of California, San Diego is a non-profit research organization within the Department of Family and Preventive Medicine. HSRC works in collaboration with the Quality Improvement Unit of the County of San Diego Behavioral Health Services to evaluate and improve behavioral 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 client quality of life. For more information please contact Andrew Sarkin, PhD at 858-622-1771.

The Child and Adolescent Services Research Center (CASRC) is a consortium of over 100 investigators and staff from multiple research organizations in San Diego County and Southern California, including: Rady Children's Hospital, University of California at San Diego, San Diego State University, University of San Diego and University of Southern California. The mission of CASRC is to improve publicly-funded mental health service delivery and quality of treatment for children and adolescents who have or are at high risk for the development of mental health problems or disorders.

APPENDIX M

PEI COMPONENTS AND PRIORITIES

Prevention and Early Intervention Priority Areas Fiscal Year 2021-23

Work Plan	Contractor	Name of Program	1-Child Trauma PEI	2-Early Psychosis	3-Youth Outreach	4-Culturally Comp	5-Older Adults	6-Early ID Symptoms
CO-03	National Alliance for Mental Illness, San Diego	Integrated Peer & Family Engagement - Next Steps						x
DV-03	Union of Pan-Asian Communities	Community Violence Services	x					
DV-04	Home Start	Community Services for Families-East Regions	x					
DV-04	North County Lifeline	Community Services for Families-N Coastal/N Inland	x					
DV-04	Social Advocates for Youth, San Diego	Community Services for Families-Central	x					
DV-04	South Bay Community Services	Community Services for Families-South Region	x					
EC-01	Jewish Family Service of San Diego	Positive Parenting Program (Triple P)	x					
FB-01	Pathways Community Services, LLC	Early Intervention for Prevention of Psychosis - Kickstart		x				
NA-01	Southern Indian Health Council, Inc.	Native American Prevention and Early Intervention				x	x	
NA-01	Indian Health Council, Inc.	Native American Prevention and Early Intervention				x	x	
NA-01	San Diego American Indian Health Center	Native American Prevention and Early Intervention			x	x		
OA-01	Union of Pan-Asian Communities	Elder Multicultural Access Support Services (EMASS)				x	x	
OA-02	Union of Pan-Asian Communities	Home Based Services - Positive Solutions				x	x	
OA-06	Southern Caregiver Resource Center	Caregiver Support for Alzheimer & Dementia Patients				x		x
PS-01	Rescue Agency Public Benefit, LLC	Suicide Prevention and Stigma Reduction Campaign - Its Up to Us				x		
PS-01	Mental Health America	Mental Health First Aid				x		
PS-01	San Diego Workforce Partnership	Supported Employment Technical Consultant Services				x		
PS-01	Mental Health Association in San Diego County	Father 2 Child				x		
PS-01	Jewish Family Service of San Diego	Breaking Down Barriers				x		
PS-01	National Alliance for Mental Illness, San Diego	Family Peer Support Program				x		
PS-01	Community Health Improvement Partners	Suicide Prevention Action Plan				x		
RC-01	Vista Hill Foundation	Rural Integrated Behavioral Health & Primary Care		x				x
RE-01	Community Health Improvement Partners	Independent Living Association (ILA)				x		
SA-01	South Bay Community Services	School Based PEI - South	x					
SA-01	Vista Hill Foundation	School Based PEI - North Inland	x					
SA-01	Palomar Family Centers	School Based PEI - North Coastal	x					
SA-01	San Diego Unified School District	School Based PEI - Central and North Central	x					
SA-01	San Diego Unified School District	School Based PEI - Central and Southeastern	x					
SA-01	San Diego Youth Services	School Based PEI - East	x					
SA-02	San Diego Youth Services	School Based Suicide Prevention & Early Intervention - HERE Now			x			x
VF-01	Mental Health Systems, Inc	Veteran & Family Outreach Education - Courage to Call				x		

PRIORITY AREAS

1 - Childhood Trauma Prevention and Early Intervention
2 - Early Psychosis and Mood Disorder Detection and Intervention
3 - Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
4 - Culturally Competent and Linguistically Appropriate Prevention and Intervention
5 - Strategies Targeting the Mental Health Needs of Older Adults
6 - Early Identification Programming of Mental Health Symptoms and Disorders

APPENDIX N

INNOVATION REPORTS



URBAN BEATS INNOVATIONS-16

Final Report
(7/1/2015 - 6/30/2020)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES (v.12.28.2020)

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO | UC San Diego

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Conclusion 17
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Appendix 19

Executive Summary

Program Overview

The Urban Beats program was designed to provide wellness education and mental health support to transitional age youth (TAY) age 16-25 who were: 1) clients of the County of San Diego Behavioral Health Services (BHS) system, 2) experiencing mental health distress, or 3) at risk of mental health challenges. Core services were provided via a structured multi-week curriculum and individualized development of desired forms of artistic expression. The arts-based focus was intended to function as a mechanism to promote youth engagement as well as help reduce mental health-related stigma in both the TAY and the community through public performances.

For Urban Beats, the onset of the COVID-19 pandemic substantially affected program services. Since all in-person interactions were suspended, this halted the delivery of the standard cohort-based classes and workshops. In addition, the social distancing restrictions required that all community performances be cancelled and studio time with youth was not feasible. Staff continued to reach out and connect with youth via phone and video calls to maintain established relationships and offer encouragement and support during challenging times.

Primary Findings

1. The arts-based approach with a strong peer support/peer empowerment component appeared to be a successful strategy for connecting with and engaging youth in a mental health wellness and stigma reduction program as demonstrated by their ability to enroll over 770 unduplicated TAY into Urban Beats. Additionally, Urban Beats participants reflected substantial diversity in race/ethnicity, primary language, sexual orientation, and gender identity.
2. For those with matched pre- and post-Urban Beats participation assessment data, youth demonstrated improved attitudes regarding mental health services as participants indicated they felt more comfortable talking to mental health professionals and were more likely to think that professional mental health services were effective.
3. It is estimated that over 5,000 persons attended the more than 130 Urban Beats community performances/events. Of the almost 4,000 completed surveys, the vast majority (84.7%) agreed or strongly agreed that as a result of the performance they had a better understanding that anyone can experience mental health challenges. Most importantly, the public performance orientation was

essential to achieving overall Urban Beats programs objectives as it provided focal activities to motivate skill-building, relationship development, growth in self-esteem and leadership capabilities, as well as further reductions in personal and community stigma related to mental health and participation in mental health services when needed.

4. While generally uncommon among Urban Beats participants, especially as more recent cohorts included primarily "at-risk" youth rather than those already with a history of receiving mental health services, analyses indicated a reduction in the utilization of County of San Diego acute/crisis behavioral health services after starting Urban Beats (e.g., inpatient psychiatric hospitalizations, crisis residential treatment, and emergency/crisis-oriented psychiatric visits).
5. Approximately 85% of participants reported being satisfied with the Urban Beats program while approximately two-thirds reported key outcomes such as symptom reduction, improved management of problems, and reduced stigma for seeking help.
6. A total of 70 Urban Beats youth participated in one-on-one sessions with the "in-house" clinician after this role was added to the team during FY 2018-19. The majority of youth received Trauma Informed Therapy, suggesting a high need for such services.

Conclusion/Future Directions

Overall, the arts-based strategy appeared to be successful for engaging youth in services. Feedback from both youth and Urban Beats staff identified how the focus on artistic expression with an expectation of public presentation/performance contributed to improvements in self-confidence and mental well-being and reductions in mental health related stigma. Additionally, preparation for community performances promoted the development of strong relationships and peer support among Urban Beats participants, while the performances themselves created opportunities for sharing positive messages with other TAY and community members.

Given the unusual circumstances surrounding the emergence of COVID-19 during the latter part of FY 2019-20 that significantly altered Urban Beat's service delivery strategies, BHS provided a short-term, one-year extension using funds unrelated to the Mental Health Services Act (MHSA) Innovations portfolio. During FY 2020-21, BHS will make the determination about investing in the long-term provision of Urban Beats services and/or consider ways to strategically incorporate the valuable lessons learned from the program about youth outreach, engagement, and support into existing and future programs.

Program Description

The County of San Diego Health and Human Services Agency's BHS Urban Beats program was funded through the Innovations (INN) component of the MHSA. Urban Beats was developed to provide TAY (age 16-25) with increased access to and knowledge of behavioral health treatment and wellness services, as well as reduce mental illness stigma for TAY and the community. The primary innovation of this program was the utilization of artistic expression to communicate a recovery-focused message to TAY and develop artistic skills and self-esteem. The program added a therapist in its third year who provided counseling and emotional support directly to Urban Beats TAY as needed. An in-house therapist was expected to

increase access to and utilization of behavioral health care by Urban Beats TAY since these services could now be accessed within the network of trusted Urban Beats relationships, rather than requiring a referral to an external provider. For TAY with significant needs, the Urban Beats therapist worked to identify and link TAY to appropriate ongoing care. Another change included the expansion into new communities such that Urban Beats grew from the initial pilot programs to operating four programs throughout the Central and North Central Regions of San Diego County.

A core activity of the Urban Beats program was a structured 20-hour curriculum that focused on improving TAY health and mental health awareness and increasing overall well-being by addressing topics such as healthy relationships, wellness and trauma, identity, goal setting, and leadership. Following the structured multi-week classes, Urban Beats staff provide individualized attention to each TAY to help develop their desired form of artistic expression and create something for public presentation/performance (e.g., drawing, poetry, song, and videography). Throughout the program, TAY presented their creations in public performances designed to build greater self-esteem among participants, educate the community about mental health issues, and reduce stigma for both the Urban Beats participants and community members.

Service Changes Due to COVID-19

The COVID-19 pandemic first affected the San Diego area in a substantial manner during March 2020. The County of San Diego issued a public health order effective 3/13/2020 to limit the size of public gatherings to less than 250 persons and to restrict access to hospitals and long-term care facilities serving seniors. This was followed by a statewide public health order on 3/19/2020 that required all non-essential workers to stay at home. During this time period, County BHS programs had to quickly adapt to the new service delivery environment to protect both client and provider safety while continuing to provide mental health services. For many programs, these changes included a switch to or greater utilization of telehealth services.

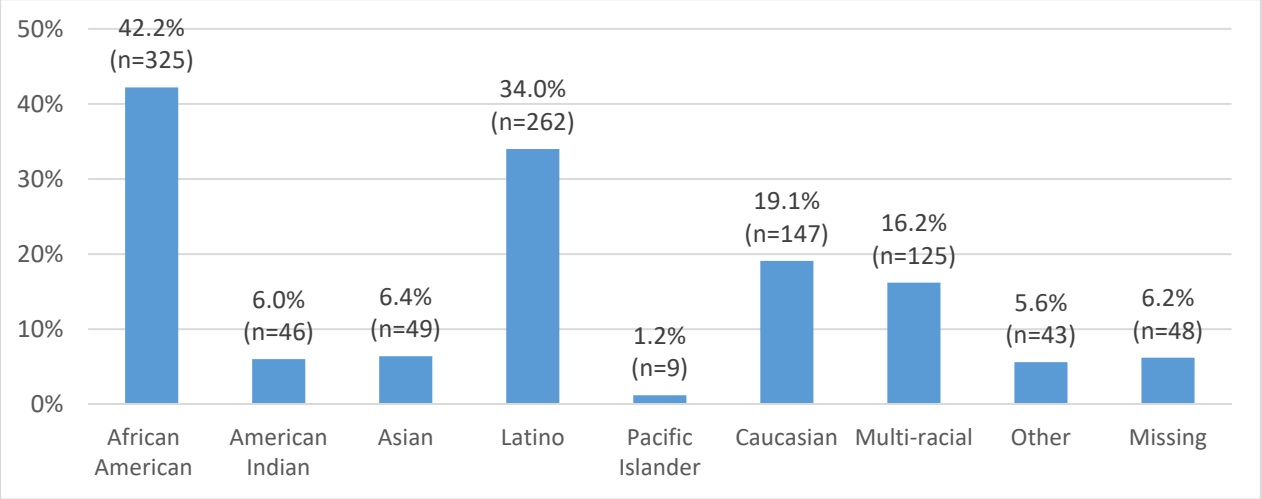
For Urban Beats, the onset of the COVID-19 pandemic substantially affected program services. Since all in-person interactions were suspended, this halted the delivery of the standard cohort-based classes and workshops. In addition, the social distancing restrictions required that all community performances be cancelled and made studio time not feasible, at least through the end of FY 2019-20. Staff continued to reach out and connect with youth via phone and video to maintain established relationships and offer encouragement and support during challenging times. The Urban Beats staff also worked to develop versions of the 20-session cohorts and workshops that would be viable for conducting remotely via video. It is expected that such services will be offered during FY 2020-21. Where relevant, findings and recommendations in this report indicate the unique challenges that COVID-19 poses within the local community and healthcare environment.

Participant Characteristics

A brief overview of the Urban Beats participant characteristics is presented here, with a more complete listing in the appendix. Urban Beats program eligibility criteria required that participants were TAY between the ages of 16 and 25. Of the 770 participants involved with Urban Beats between FY 2015-16 and FY 2019-20, the majority were male (53.4%), spoke English (71.8%), and identified as heterosexual (69.1%). When asked to indicate a disability that was not the result of a Serious Mental Illness (SMI), 24.6% indicated having a disability, with 10.9% reporting a learning disability specifically. As shown in Figure 1,

Urban Beats participants were racially and ethnically diverse with no single population group representing more than 50% of the population.

Figure 1. Race/Ethnicity of Youth Enrolled in Urban Beats between FY 2015-16 and FY 2019-20 (N=770).



Note: Total may exceed 100% since more than one race/ethnicity could be selected.

Primary Program Outcomes

Urban Beats Participant Beliefs

Urban Beats participants were asked to complete a Wellness Survey, which includes select items from the Recovery Markers Questionnaire (RMQ) at the start of classes, 6 weeks later, and at the end of the 20-week program. To identify areas of change, the responses from participants who completed both a baseline and a follow-up survey are listed in Table 1. The table presents the average rating at baseline and the most recent follow-up for everyone involved in the program with both baseline and follow-up data (n=122). Additionally, to investigate the potential that participants have differing perspectives based on their self-reported mental health status at baseline, findings are presented separately for those who indicated low mental health (i.e., poor or fair; n=38) and high mental health (i.e., good, very good, or excellent; n=84).

Overall, at baseline, the most commonly endorsed statements (i.e., those with the highest means) focused on participants' beliefs about their self-efficacy (#12) and pursuit of goal achievement (#6). Participants appeared to be less enthusiastic about their stress management capabilities (#11) and having sufficient income (#4). These findings indicate that Urban Beats was enrolling TAY who were generally goal-oriented and optimistic about what they can accomplish, but who were also concerned about their ability to handle stress and having sufficient financial resources—two key issues addressed by the Urban Beats program.

Table 1. Urban Beats Participant Beliefs – Baseline and Follow-up Comparisons (N=122)

		Overall (n=122)		Baseline Mental Health: Low (n=38)		Baseline Mental Health: High (n=84)	
#	Item	Initial Mean	Follow Up Mean	Initial Mean	Follow Up Mean	Initial Mean	Follow Up Mean
1	In general, how would you rate your satisfaction with your social activities and relationships	3.3	3.4	2.3	2.7^	3.7	3.7
2	I have at least one close mutual relationship	4.0	4.1	3.7	3.8	4.1	4.2
3	I am involved in meaningful, productive activities	3.8	4.0	3.4	3.9**	4.0	4.0
4	I have enough income to meet my needs	2.9	3.2*	2.4	2.8*	3.1	3.3
5	I am using my personal strengths, skills, or talents	3.9	4.0	3.4	3.6	4.0	4.1
6	I have goals I'm working to achieve	4.2	4.3	3.8	4.1	4.4	4.3
7	I contribute to my community	3.6	3.8^	3.4	3.6	3.7	3.9
8	I have a sense of belonging	3.7	3.8	2.9	3.2	4.0	4.0
9	I feel hopeful about my future	4.0	4.1	3.6	3.9^	4.2	4.2
10	I treat myself with respect	3.8	4.0*	2.9	3.4*	4.2	4.3
11	I am able to deal with stress	3.4	3.6*	2.7	3.2*	3.7	3.8
12	I believe I can make positive changes in my life	4.1	4.4**	3.7	4.2**	4.3	4.4
13	Mental health services can effectively improve mental health	3.6	4.0**	3.5	4.1**	3.7	4.0*
14	I would feel comfortable talking to a mental health professional	3.5	4.0**	3.6	4.1*	3.5	3.9**

*^statistical significance at p < 0.10; *statistical significance at p < 0.05; **statistical significance at p < 0.01; Scale values: 1=Strongly disagree, 2=Disagree, 3=Neutral, 4=Agree, and 5=Strongly agree.*

Participants who reported having lower mental health at baseline typically also indicated lower baseline values across other Wellness Survey items. At follow-up, ratings across all items stayed the same or increased for both groups of participants, with the persons who indicated lower baseline mental health generally demonstrating larger improvements. Statistically significant changes unique to this group were evident in their participation in meaningful activities (#3), having sufficient income (#4), ability to manage stress (#11), and beliefs about personal positive self-efficacy (#12).

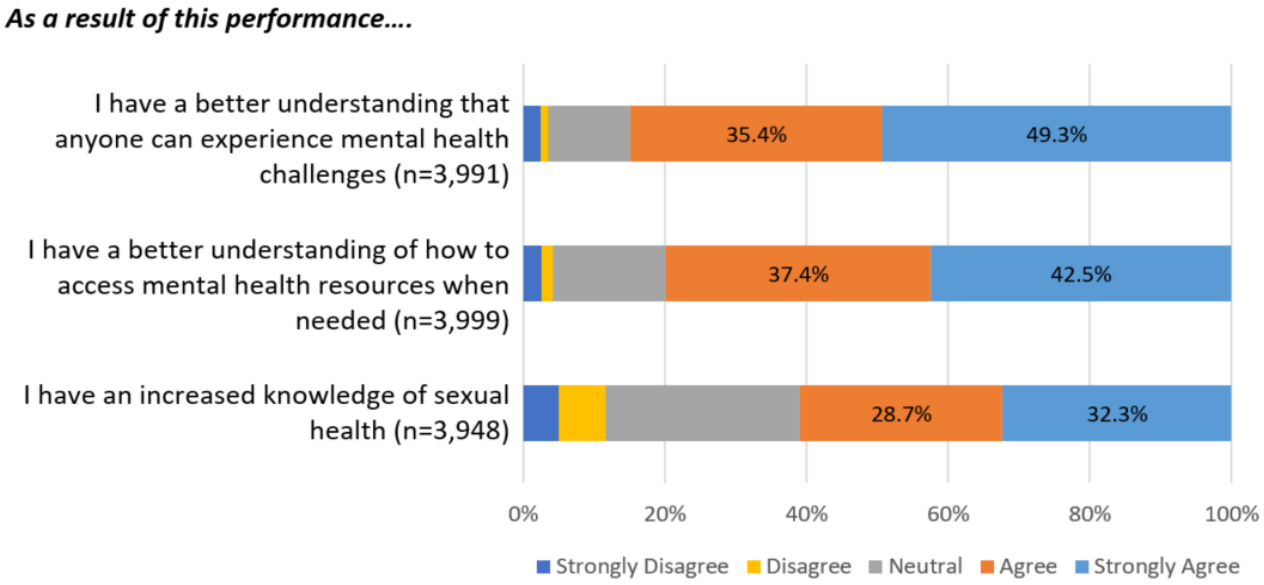
These findings suggest that participants who felt more negative about their mental health upon entry into Urban Beats were typically able to experience significant improvements in multiple domains central to

the goals of the program. Persons who entered Urban Beats with more favorable perceptions about their own mental health were able to maintain or slightly improve their already more positive outlook on these domains. For both groups, their attitudes regarding mental health services significantly improved, with initial scores of around 3.5 (i.e., neutral/agree) and follow-up scores around 4.0 (i.e., agree) in their sense that mental health services can improve mental health (#13) and feeling comfortable talking to a mental health professional (#14). These findings reflect success at improving perceptions about mental health services among both types of Urban Beats program participants.

Community Performance Outcomes

Over the life of the program (FY 2015-16 to FY 2019-20) Urban Beats hosted or co-hosted over 130 different community performances/events. It is estimated that over 5,000 persons attended these performances/events and 3,999 completed an outcome survey (note: surveys were not able to be distributed at all events). Transitional age youth (ages 16-25) comprised 70.3% (n=2,844) and persons younger than 16 comprised another 10.2% (n=412) of the audience. Participants were asked to indicate the extent to which they agreed or disagreed with each statement on a 5-point scale. As shown in Figure 2, a majority of all respondents (84.7%) agreed or strongly agreed that as a result of the performance they had a better understanding that anyone can experience mental health challenges. A similar percent (79.9%) also agreed or strongly agreed that they had a better understanding of how to access mental health resources, while somewhat fewer agreed or strongly agreed that the performance increased knowledge of sexual health (61%).

Figure 2. Assessment of Community Performance Attendee Learning (N=3,999)



The response patterns between TAY and persons older than TAY who attended the performances were fairly similar for the three outcome questions. For persons younger than 16, the percent who agreed or strongly agreed that they "had a better understanding that anyone can experience mental health challenges" was also similar (i.e., approximately 74.6%); however, in comparison to TAY, they indicated slightly lower rates of "better understanding how to access mental health resources" (70.6% compared

to 82.2%) and substantially lower rate of “increased knowledge of sexual health” (46.9% compared to 65.5%) as a result of the performance.

Utilization of BHS Services by Urban Beats Participants

To assess the extent to which participation in Urban Beats may be associated with changes in BHS service utilization patterns, BHS service use by Urban Beats participants was examined 180 days before and 180 days after starting the Urban Beats program. To ensure that everyone included in the analyses had the entire 180 days to be observed for any behavioral health service utilization after starting Urban Beats, the analyses only included participants (n=659) who started the Urban Beats program at least 180 days prior to the end of the 6/30/2020 reporting period.

As shown in Table 2, 16.8% of the 659 Urban Beats ‘life-of-program’ participants included in the 180-day analyses attended at least one behavioral health outpatient visit within the 180 days prior to starting the Urban Beats program and slightly less than 10% (8.6%) participated in Assertive Community Treatment (ACT). There was little change in participation rates for outpatient visits while the participation rate and number of total visits for ACT had a modest increase (9.1%; 2,304 vs 2,523 visits).

While less frequent overall, the findings in Table 2 indicate that acute/crisis care oriented services such as Psychiatric Emergency Response Team (PERT) contacts, emergency psychiatric hospital visits, inpatient psychiatric hospitalizations, and justice-related mental health services (e.g., services received while in jail or participating in behavioral health court proceedings), were utilized less often after participants had started the Urban Beats program. For example, while 5.8% had an inpatient psychiatric hospitalization in the 180 days before starting Urban Beats, only 3.2% had a hospitalization after starting Urban Beats (a 45% reduction in the hospitalization rate; total admissions reduced from 73 to 37). There was also a substantial decrease in admission rate and total number of admissions to crisis residential treatment after starting Urban Beats (3.6% vs 1.1%; 30 vs 7 admissions).

Given the relatively low utilization rates of most acute/crisis care-oriented services, these findings should be interpreted with caution; however, the overall pattern suggests that participation in Urban Beats was associated with lower utilization of public mental health acute/crisis-oriented services.

Table 2. County BHS Utilization before and after Starting Urban Beats (N=659)

	180 Days Before Start Urban Beats			180 Days After Start Urban Beats		
	Persons with at least one session	% of Urban Beats population	Sum of visits	Persons with at least one session	% of Urban Beats population	Sum of visits
Outpatient Visits	111	16.8%	1,248	106	16.1%	1,216
Assertive Community Treatment (ACT)	57	8.6%	2,304	60	9.1%	2,523
Urgent Outpatient	34	5.2%	55	28	4.2%	39
Crisis Stabilization	20	3.0%	27	9	1.4%	15
Psychiatric Emergency Response Team (PERT)	23	3.5%	29	14	2.1%	19
Justice-Related Mental Health Visit	16	2.4%	57	11	1.7%	38
	Persons with at least one admission	**% of Urban Beats population**	**Sum of admissions**	**Persons with at least one admission**	**% of Urban Beats population**	**Sum of admissions**
Inpatient Psychiatric Hospital Admit	38	5.8%	73	21	3.2%	37
Crisis Residential Treatment	24	3.6%	30	7	1.1%	7

Participant Assessment of the Urban Beats Program

As shown in Table 3, the vast majority (83.7%) of Urban Beats participants with follow-up Wellness Survey data indicated that they were satisfied with the Urban Beats program (#1; 35.6% agreed and 48.1% strongly agreed) and a similar percentage (84.4%) felt appropriately supported by the Urban Beats staff (#2; 35.9% agreed and 48.5% strongly agreed). Participants who indicated that they had lower mental health upon program entry tended to be slightly more favorable about their experiences with Urban Beats, particularly in regard to feeling appropriately supported by staff (96.3% agreed/strongly agreed as compared to 84.4%, respectively). This suggests that while Urban Beats staff effectively engaged with

most participants, they were especially skilled at connecting with and supporting participants who were experiencing mental health-related difficulties when they entered the Urban Beats program.

Table 3. Urban Beats Participant Assessment of the Urban Beats Program (N=104)

		Overall			Baseline Mental Health: Low (n=27)			Baseline Mental Health: High (n=76)		
#	Item	Agreed Total	Agree (Strongly Agree)	Mean	Agreed Total	Agree (Strongly Agree)	Mean	Agreed Total	Agree (Strongly Agree)	Mean
1	Overall, I am satisfied with the services I received	83.7%	35.6% (48.1%)	4.3	88.8%	44.4% (44.4%)	4.3	81.6%	32.9% (48.7%)	4.2
2	I felt appropriately supported by staff when I encountered challenges	84.4%	35.9% (48.5%)	4.3	96.3%	40.7% (55.6%)	4.5	80.0%	33.3% (46.7%)	4.2
As a result of the program…		**Agreed Total**	**Agree (Strongly Agree)**	**Mean**	**Agreed Total**	**Agree (Strongly Agree)**	**Mean**	**Agreed Total**	**Agree (Strongly Agree)**	**Mean**
3	I know where to get help when I need it	82.7%	46.2% (36.5%)	4.2	74.1%	51.9% (22.2%)	4.0	85.5%	43.4% (42.1%)	4.2
4	I am more comfortable seeking help	69.9%	38.8% (31.1%)	3.9	66.6%	48.1% (18.5%)	3.8	70.7%	34.7% (36.0%)	3.9
5	I deal more effectively with daily problems	64.1%	47.6% (16.5%)	3.7	59.3%	51.9% (7.4%)	3.6	65.3%	45.3% (20.0%)	3.8
6	My symptoms are bothering me less	62.5%	36.5% (26.0%)	3.8	55.5%	40.7% (14.8%)	3.6	64.5%	34.2% (30.3%)	3.8

The majority of participants indicated that as a result of the Urban Beats program, they knew where to get help (#3; 82.7%), felt more comfortable seeking help (#4; 69.9%), dealt more effectively with daily problems (#5; 64.1%), and were less bothered by symptoms (#6; 62.5%). The results were fairly similar between the two self-reported mental health groups of Urban Beats participants, however, a slightly larger proportion of the participants who entered the program with more favorable perceptions of their mental health indicated they agreed or strongly agreed with experiencing these outcomes. These findings suggest that while most youth experienced a range of positive benefits from participating in the Urban

Beats program, there continues to be a need for improvements, particularly among youth who enter the program with more significant mental health difficulties.

Findings from focus groups conducted with Urban Beats youth provided additional information regarding youth perceptions of the program. Overall, the language that youth used to describe their experiences with Urban Beats indicated that the staff had successfully adopted a strengths-based approach that highlighted the resilience and capabilities of the youth rather than focusing on deficiencies and "problems." Youth indicated that they were very satisfied with the program and that they understood and supported the goals of Urban Beats. Consistent with the quantitative survey data, youth spoke very positively about their interactions with Urban Beats staff and indicated that the support and recognition they received from staff was highly valued.

As a change from the original, linear form of anticipated Urban Beats program participation (i.e., youth enter and proceed through a class cohort and then leave the program upon successful completion), Urban Beats participants from prior cohorts often returned to participate in and help out with subsequent courses and performances. For this reason, the group of youths involved with Urban Beats often had various levels of prior interactions and experience with the program. Youth indicated that the ability to stay connected to Urban Beats beyond their initial cohort helped to support ongoing growth and learning.

Youth focus group participants frequently identified experiencing positive outcomes in the following domains:

1. Improved mental well-being/better stress management.
2. Enhanced skills in their preferred form of creative expression.
3. Better ability to communicate with others (particularly regarding mental health).
4. Greater sense of self-confidence and self-empowerment that helped them try new things.
5. Increased social support from other TAY, from Urban Beats staff, and from connections Urban Beats facilitated at other community organizations.
6. Increased capacity for leadership, goal setting, and goal attainment.

Youth also indicated that these skills and experiences laid the groundwork for accomplishing larger ambitions, such as identifying what careers they might want to pursue and giving them the skills and confidence to achieve their goals. Some youth, especially those who had participated in multiple rounds of Urban Beats cohorts, reported that either they themselves or others from their cohort had found jobs in entertainment/the arts or in mental health fields working as peers.

The following quotes from some of Urban Beats participants capture the transformative power of the opportunities, education, and support provided by and through Urban Beats participation:

"The first time I read one of the first poems I ever wrote was at an open mic that Urban Beats would take us to. I was so nervous I almost didn't read it, but with the support of Urban Beats I read it and the crowd's reaction to my poem was priceless. I never in my life felt support like that till that day. From that day on my life has never been the same. I felt for the first time in my life, I actually felt comfortable being me."

"They quite literally saved my life and helped me make healthier choices."

Utilization of Therapeutic Services Provided by the Urban Beats Clinician

Based on experiences during the early years of the Urban Beats program, particularly the ongoing challenges of connecting youth to formal behavioral health services when needed, the Urban Beats program added an "in-house" behavioral health clinician (pre-licensed) who could meet directly with Urban Beats participants. A total of 70 Urban Beats youth participated in one-on-one sessions with the clinician since this service was added during FY 2018-19. It is estimated that approximately 20% of Urban Beats youth active during this time frame participated in at least one session with the clinician. The 42 youth with detailed clinician service contact data received a total of 336 sessions (median number of sessions = 5). As shown in Table 4, a wide variety of services were provided during sessions and more than one service type could be provided in a single session. Cognitive Behavioral Therapy was the most common service provided (39.6%), followed closely by Trauma Informed Therapy (37.5%). Approximately 5.0% of all sessions were directly related to providing crisis intervention services (4.8%). Of these 42 Urban Beats youth participating in sessions with the clinician, 71.4% (n=30) had at least one session of Trauma Informed Therapy. This indicates a high need for trauma informed care among Urban Beats youth.

Table 4. Primary Types of Clinician Delivered Services (N=336 sessions)

	Total Sessions	
Type of Service	**N**	**%**
Cognitive Behavioral Therapy	133	39.6%
Trauma Informed Therapy	126	37.5%
Discharge planning	20	6.0%
Crisis Intervention	16	4.8%
Case Management	13	3.9%
Safety Assessment/ Planning	12	3.6%
Solution Focus Therapy	10	3.0%

Community Partner Feedback

The Urban Beats program interacted with a wide range of community organizations including schools, social services agencies, mental health providers, and other arts and culture organizations. A brief online survey was conducted with representatives of these community organizations to better understand their perceptions of the Urban Beats program. For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses and any discrepancies were discussed to arrive at a consensus on the key response themes. Representatives from 13 of the 26 invited community agencies completed the survey for a 50% response rate. All respondents (n=13) indicated that Urban Beats provided important services to youth with 84.6% (n=11) saying that the collaborations with Urban Beats helped their organization achieve desired goals/objectives. Respondents also indicated that collaborations often included Urban Beats conducting trainings and workshop events with their youth on leadership, relationships, communication, arts, self-care, and mental health awareness. In addition to these workshops and trainings, Urban Beats collaborated with schools to offer mental health support services as well as after school enrichment activities.

When asked about the effect of the Urban Beats program, community partners reported a positive impact of the program in reducing the stigma of mental health while also providing mental health services. Community partners largely reported that the success of Urban Beats was due to the program staffs' ability to effectively engage and communicate with TAY, which led to a safe space for TAY to grow and develop confidence, skills, knowledge, and peer relationships. Overall, community partners reported being grateful for Urban Beats and the support, resources, and opportunities that were provided since they saw improved mental health, self-esteem, creativity and self-expression within their organization/clientele.

Additional Program Activities

Social Media Presence

The Urban Beats program developed a website (https://www.sdurbanbeats.org/) to help raise awareness of available program services, share information about other community resources, and promote upcoming performances. As of 6/30/2020, the website had recorded 116,140 visits. Additionally, Urban Beats had 1,056 Instagram followers, 726 Facebook "likes," 137 Twitter followers, and 1,725 SoundCloud plays.

TAY Engagement Trainings for Community Partners

In addition to their work directly with TAY, Urban Beats staff also conducted trainings with the staff of other community organizations to share their knowledge about how to increase TAY engagement in services. During FY 2019-20, a total of 10 such trainings were provided to 171 persons representing a wide range of community organizations (e.g., YMCA, SDSU, Mesa College, and Father Joe's).

Primary Implementation Findings

Findings reported in this section were derived from three primary data sources: 1) stakeholder meetings, 2) the Annual Urban Beats Staff Survey, and 3) focus groups conducted with Urban Beats staff. The stakeholder meetings were held throughout the year with representatives from BHS, Urban Beats, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual Urban Beats Staff Survey was conducted yearly throughout the MHSA Innovations Urban Beats program to generate feedback about staff experiences with, perceptions about, and recommendations for program implementation and operation. Staff focus groups were held periodically throughout the program to get more detailed feedback on program operations, challenges, and perceived opportunities.

Arts-Based Service Strategy

An arts-based curriculum was perceived to be an effective approach to engage TAY in a behavioral health-oriented outreach and support program, and, in particular, an important approach for racial/ethnic and sexual orientation minorities who may be uncomfortable and underserved in more traditional mental health service settings. There were five key benefits associated with utilizing an arts-based approach to provide services to TAY:

1. The arts-based approach facilitated outreach and recruitment as it had more intrinsic appeal compared to recruiting for something such as a "wellness class."
2. The arts-based approach facilitated relationship building via organic one-on-one mentorship with Urban Beats staff as well as providing opportunities for positive social relationships with peers while collaboratively practicing/preparing their art forms.
3. The ability to engage in artistic expression was viewed as a benefit in its own right as the subject matter of the art frequently related to the youth's experiences with loss, joy, struggle, or healing that helped youth think about and process their own emotions in a manner that promoted positive well-being.
4. The arts-based approach allowed the youth to have an end product, whether in the form of music, poetry, visual arts, etc., that could be used to engage with the broader community. Since their art was often intended to prompt discussion about well-being, acceptance, and the normalization of mental health challenges, the act of sharing their art provided important, destigmatizing messages to other TAY and community members.
5. The arts-based approach coupled with an expectation of public engagement (rather than solely for private, personal enrichment) created opportunities for personal growth, such as increased self-confidence by sharing their art with others, as well as additional skill and leadership building opportunities since youth were often involved with planning for and organizing the public performance activities.

Overall, the arts-based approach helped to facilitate the core objectives of engaging youth and providing them meaningful opportunities to increase their well-being and knowledge in a safe and socially supportive context.

Staff Characteristics

Staff indicated that techniques such as active listening worked well with youth and that they were able to relate to youth due to their own personal experiences. Staff also had education and/or work experience in mental health or social work which helped to address youth needs for emotional support and mental health well-being. Staff continued to be sensitive and adaptive, leveraging their diverse life experiences and prior engagement in mental health services to build rapport with youth and made sure to check in regularly. The personal "lived experience" of Urban Beats' staff having received mental health services in their own past facilitated connections with TAY and discussions about accessing needed services. The unique and wide set of staff skills and passions also helped to facilitate youth engagement, empowerment, and the development of their artistic talents.

Community Performance Component

During the second year of Urban Beats operations (FY 2016-17), Urban Beats managers and staff decided to increase the number of performances throughout the program. Using a flexible approach, many smaller performances were offered such as monthly open-mic nights. Staff indicated that despite initial concerns about the burden of more performances, youth rose to the challenge and thrived with the new schedule and the increased opportunities to refine their art, network with other artists, and build their confidence. Staff also indicated that increasing the number of performances led to more co-hosted events and more

connections with other community organizations. The shift to have more community performance opportunities instead of only a few high-profile events also lessened administrative planning burdens by establishing regularly scheduled community performances (e.g., open-mic nights every 3rd Friday of the month) and helped with outreach/advertising since times and locations were known well in advance. Having a community performance component of the program was identified as essential for achieving the program goals of the Urban Beats program. In particular, Urban Beats staff identified specific benefits of having a community performance component. The performances:

1. Provided a specific event to focus Urban Beats educational and mentorship activities around.
2. Encouraged TAY to express themselves publicly and build self-confidence.
3. Functioned as "platform" for communicating a mental health stigma reduction message to the community.
4. Increased awareness of the Urban Beats program to facilitate TAY recruitment and other organizational partnerships.
5. Required youth to develop other skills needed to create, plan, and execute the event, in addition to showcasing their artistic talents.

Mental Health Related Stigma Reduction

A core objective of the Urban Beats program was to reduce stigma related to mental health needs and service utilization. As reported in other sections of this report, it appears that Urban Beats was successful in reducing such stigma among both Urban Beats participants and the broader community via the performance activities. The following are the specific mechanisms identified by the Urban Beats staff that contributed to these stigma reduction achievements:

1. Staffing Urban Beats with compassionate persons who had "lived experience" both needing and utilizing mental health services.
2. Providing a safe and non-judgmental environment for TAY to hear and discuss life experiences with other TAY.
3. Offering psychoeducation in a relatable context.
4. Improving comfort levels with discussing mental health issues and services.
5. Facilitating youth-to-youth peer supports over an extended period of time through program participation.
6. Allowing TAY to communicate their stories to the community in creative and empowering manners.
7. Starting the conversation among the community regarding mental health stigma through public performances.
8. Using social media presence to provide education and reduce stigma for other TAY.

Recruitment Strategies

Urban Beats staff identified the following as effective approaches to identify and connect with potential Urban Beats participants:

1. Use Urban Beats community performances to educate other youth about Urban Beats.
2. Encourage youth "word-of-mouth" by current and former Urban Beats participants.
3. Develop partnerships with other youth serving community organizations.
4. Actively recruit youth receiving services in other mental health programs.
5. Develop and utilize social media presence to increase awareness of the Urban Beats program.
6. Conduct presentations/outreach in schools.
7. Targeted recruitment at homeless shelters for TAY.

Experiences with Telehealth Services

With COVID-19, the Urban Beats program shifted from providing primarily in-person services to only interacting with clients virtually via telephone or video telehealth calls. When asked to compare experiences between in-person and telehealth services, staff indicated that their relationships with participants suffered and that many TAY were unwilling to schedule virtual services or follow through with scheduled appointments. Overall, staff noted that TAY engagement with the program declined when the program shifted from in-person to virtual services. However, Urban Beats staff were very confident in their ability to provide services via telehealth and agreed that telehealth should remain a priority for the program even after in-person services become safe and available again.

According to Urban Beats staff, 11-25% of TAY were unable to consistently utilize telehealth with video due to problems with internet connectivity or other technical challenges managing video calls. Recommendations for overcoming barriers to working with TAY virtually and for facilitating telehealth video sessions included providing options for internet access and/or devices enabled for telehealth. Although telehealth services can provide greater flexibility in scheduling, Urban Beats staff noted that TAY were reluctant to schedule virtual services and that even when video calls were possible, staff estimated that approximately 10% of clients preferred telephone only sessions.

The challenges with engaging youth in telehealth services, particularly video, have been particularly evident for the clinician. While the clinician continued to offer one-on-one support and therapy services via telehealth, it has been difficult to keep Urban Beats participants engaged and interested in receiving consistent therapy without the rest of the overall Urban Beats service experience. A few clients have requested phone sessions since the start of the program operating remotely, but they frequently cancel. Although offered, there has been no interest in or requests for face-to-face sessions via video telehealth options.

Impact of COVID-19 on Urban Beats Staff

Urban Beats staff overwhelmingly indicated that COVID-19 had changed their work settings due to the transition away from in-person services to the use of virtual services. The lack of contact and connection with people was reported as having the biggest impact on their work tasks. Staff also reported substantial changes in their lives unrelated to work and most indicated experiencing additional stress and anxiety. Staff reported using self-care, personal interests and hobbies, and social connections to help manage or reduce COVID-19 related stress or anxiety.

Program Changes from Initial Design

The Urban Beats program was initially designed to include two primary service components: 1) a 20-week course that integrated education on mental health wellness and mentorship on a preferred form of artistic expression and 2) performances that showcased the art forms developed by TAY and disseminated positive messages intended to increase understandings of mental health wellness and reduce mental health-related stigma. Prior to COVID-19, the following key changes from original plans were implemented in response to identified needs and opportunities:

1. Expanding the Urban Beats program to serve additional communities in the Central and North Central regions of San Diego.
2. Allowing youth to stay involved in Urban Beats activities after completing the wellness course in order to facilitate ongoing learning and create opportunities for youth-to-youth mentorship. Graduates from earlier cohorts could support youth who were going through the course for the first time and assist with organizing Urban Beats activities.
3. Increasing the frequency and types of community performances to include more options ranging from large formal events (e.g., concerts and community festivals) to smaller, more informal, activities (e.g., open-mic events).
4. Redesigning the wellness course to offer both the original 20-week course structure as well as new "20-hour" courses that could be provided in a more condensed format with youth meeting together for longer periods of time over a fewer number of weeks. Allowing for both options enabled the programs to better tailor their offerings to the availability of youth and their interests.
5. Creating one-time "workshops" during which select topics from the main course would be provided to youth without requiring youth to commit to a multi-week course.
6. Developing "studio-time" and drop-in opportunities that allowed youth to come to the Urban Beats facilities to work on their artistic expression using available Urban Beats equipment and materials while receiving mentorship from Urban Beats staff.
7. Adding an Urban Beats van partway through the program was viewed as an invaluable resource that substantially reduced transportation barriers. The van supported program objectives by transporting youth to Urban Beats classes and other activities, transporting equipment and youth to community performances, and helping youth get to appointments with other service providers.
8. Adding a pre-licensed clinician was generally viewed favorably by helping meet the need for therapeutic services among youth who were not interested in referrals to external services. However, the clinician was not as consistently busy with providing therapy services to Urban Beats youth as expected. In this manner, the role of a clinician within the Urban Beats program may need to be reevaluated to better align the availability of the service with the extent to which youth will realistically utilize the "in-house" counseling option.

As described in other report sections, the onset of COVID-19 dramatically altered Urban Beats program activities by suspending all in-person activities and community performances for the final quarter of FY 2019-20. During this time period, Urban Beats staff maintained connections to participants via phone and video interactions. Staff also worked on retooling other service components such as the wellness course

and workshop materials to be more amenable to delivery via video formats. These efforts are expected to result in the provision of new methods of recruiting and interacting with Urban Beats youth during FY 2020-21. Additionally, building from existing relationships with local schools, Urban Beats was exploring opportunities to partner with schools in order to support their efforts to connect with students and help address mental health needs during this time of remote learning for the school systems.

Conclusion

Throughout the Urban Beats program (i.e., FY 2015-16 to FY 2019-20), a total of 770 unduplicated TAY enrolled in the Urban Beats program who reflected substantial diversity in race/ethnicity, language, sexual orientation, and gender identity. Program services changed throughout the project in response to identified needs. Whereas initial services only included a structured 20-week curriculum that focused on wellness topics and individualized artistic mentorship that concluded in a final performance, by the end of the project there were more flexible 20-hour configurations of the full curriculum that could be offered over a fewer number of weeks, the provision of one-session topical workshops, an "in-house" clinician who could provide one-on-one therapy without requiring a referral to external services, studio and drop-in times to use equipment and meet with Urban Beats staff, and a much more expanded array of large and small performance opportunities.

Of the participants with pre- and post-Urban Beats data, it generally appeared that the program was able to achieve key goals of improving youth well-being and reducing stigma associated with mental health needs and participation in mental health services. Feedback from youth indicated high levels of satisfaction with the program services and staff, and focus group participants articulated outcomes that were consistent with program objectives. Both youth and staff highlighted the importance of the public presentation/performance component of the program. Among other benefits, the engagement with the public gave the artistic development activities a specific focus, provided opportunities for personal growth and social connectedness, and helped reduce stigma among TAY and community members by sharing and discussing mental health challenges.

While the analysis of BHS service utilization did not provide evidence of many new linkages to outpatient or ACT services, the results suggested a reduced need for crisis/acute services after starting Urban Beats (although there were generally low levels of use during both time periods). It is likely that some of the need for mental health services was met via participating in counseling sessions with the Urban Beats clinician. It is estimated that approximately 20% of the Urban Beats participants active in the program after the clinician was added to the team received at least one counseling session. This indicates a substantial need for such services, however, the role may benefit from additional review to determine the most effective integration within Urban Beats as there were some concerns that the clinician services were not utilized as extensively as anticipated.

Overall, the Urban Beats program was successfully able to establish multiple locations utilizing an art-based approach for engaging youth and providing education and support related to mental health challenges. Urban Beats has developed an extensive network of community partners including schools, social service and mental health providers, and other arts and cultural organizations to help recruit youth and host events in the community. The onset of the COVID-19 pandemic substantially disrupted the flow of normal operations when all in-person interactions were suspended during the final months of FY 2019-20. As of 6/30/2020, Urban Beats staff were continuing to maintain communication with participants via

telephone and video and were in the process of adapting other Urban Beat services, such as the structured curriculum, to be more amendable to delivery via remote learning platforms.

Future Directions

Given the unusual circumstances surrounding the emergence of COVID-19 during the latter part of FY 2019-20 that significantly altered service delivery strategies, BHS provided a short-term, one-year extension of the Urban Beats program using funds unrelated to the MHSA Innovations portfolio. In this regard, the Innovations phase for Urban Beats ended on 6/30/2020. During FY 2020-21, BHS will make the determination about investing in the long-term provision of Urban Beats services and/or consider ways to strategically incorporate the valuable lessons learned from the program about youth outreach, engagement, and support into existing and future programs.

For more information about this Innovation program and/or the report please contact:
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Appendix

Participant Characteristics

Characteristic	Total Participants (N=770)	
Gender	N	%
Male	411	53.4%
Female	282	36.6%
Transgender	6	0.8%
Genderqueer/Gender non-conforming	15	1.9%
Questioning/Unsure/Another gender identity	6	0.8%
Missing/Prefer not to answer	50	6.5%
Total	770	100%
Age Group	N	%
14-17	152	19.7%
18-21	340	44.2%
22-29	234	30.4%
Missing/Prefer not to answer	44	5.7%
Total	770	100%
Primary Language	N	%
American Sign Language	6	0.8%
Arabic	6	0.8%
English	553	71.8%
Spanish	61	7.9%
Somali	21	2.7%
Swahili	50	6.5%
Other	40	5.2%
Missing/Prefer not to answer	33	4.3%
Total	770	100%
Race/Ethnicity	N	%
African American	325	42.2%
American Indian	46	6.0%
Asian	49	6.4%
Latino	262	34.0%
Pacific Islander	9	1.2%
Caucasian/white	147	19.1%
Multi-racial	125	16.2%
Other	43	5.6%
Missing	48	6.2%
Total[1]	-	-

Characteristic	Total Participants (N=770)	
Sexual Orientation	N	%
Heterosexual or straight	532	69.1%
Gay or lesbian	26	3.4%
Bisexual/Pansexual/Sexually fluid	80	10.4%
Queer	10	1.3%
Questioning/Unsure of sexual orientation	10	1.3%
Another sexual orientation	7	0.9%
Missing/Prefer not to answer	105	13.6%
Total	770	100%
Military Status	**N**	**%**
Never served in the military	690	89.6%
Previously served in the military	7	0.9%
Other/Missing/Prefer not to answer	73	9.5%
Total	770	100%
Disability	**N**	**%**
Yes, Has a disability	189	24.6%
No, Does not have a disability	477	61.9%
Declined/Preferred not to answer	104	13.5%
Total	770	100%
Type of Disability	**N**	**%**
Seeing	67	8.7%
Hearing	17	2.2%
Other Communication	6	0.8%
Learning	84	10.9%
Developmental	8	1.0%
Other Mental	16	2.1%
Physical	9	1.2%
Chronic Health	14	1.8%
Other	23	3.0%
Total[2]	-	-

[1] *Total may exceed 100% since more than one race/ethnicity could be selected.*
[2] *Since participants could select more than one specific non-mental health related disability, the percentages may total more than the percent who indicated having any disability.*



COGNITIVE REHABILITATION AND EXPOSURE/SORTING TREATMENT (CREST)

INNOVATIONS-17

Final Report
(7/1/2015 - 6/30/2020)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES (v.12.28.2020)

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO | UC San Diego

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Executive Summary

Program Overview

The Cognitive Rehabilitation and Exposure/Sorting Treatment (CREST) program was developed to reduce hoarding behaviors among adults age 60 and older through a unique treatment approach that integrated cognitive training and exposure therapy with care management, peer support, linkages to community services, and periodic assessments and evaluations to track progress. Throughout the duration of the 26-session CREST program, services were provided in the participant's home (at least until the COVID-19 pandemic during the latter part of Fiscal Year [FY] 2019-20, which required a shift to phone and video interactions). CREST services were provided by a multi-disciplinary team of UC San Diego psychologists, social workers, care managers, and peer support specialists.

Primary Findings

1. Assessment results across multiple tools demonstrated clinically significant and meaningful improvement among participants in each of the following domains: clutter severity, functional impairment, mobility impairments, risk for homelessness, eviction avoidance, fall/injury risk, and depression and anxiety.
2. CREST team members prevented 25 evictions from occurring by collaboratively developing and implementing plans with participants, property managers/owners, and where relevant, public agencies such as code enforcement to mitigate issues prior to eviction.
3. While demonstrating substantial improvements among CREST program completers, some participants still met criteria for hoarding disorder and required additional treatment and/or some form of aftercare (e.g., support groups) to minimize the risk of post-treatment relapse.

Additional Program Highlights

1. Between FY 2015-16 and FY 2019-20, a total of 173 participants enrolled into the CREST program. The average age of enrollees was 69.2 years. The majority of participants were female (68.8%; n=119), spoke English as their primary language (91.9%; n=159), and identified as heterosexual (77.5%; n=134). Approximately 10% (9.8%; n=17) reported previously serving in the military.

2. CREST participants frequently experienced other significant challenges such as comorbid mental health conditions, other physical and brain-related disabilities, chronic health concerns, social isolation, and limited economic resources available to obtain needed services
3. The Peer Support Specialist role (i.e., someone who had prior experience with successfully responding to hoarding disorder treatment), was particularly important for developing trust with participants and providing additional emotional support and encouragement along with opportunities to practice skills learned in the therapy sessions.

Conclusion/Future Directions

Although achieving clinically significant positive outcomes with many CREST participants, unanticipated budgetary limitations coinciding with the onset of the COVID-19 pandemic resulted in a decision to not continue funding the CREST program after the conclusion of the MHSA Innovations funding on 6/30/2020. Efforts by the CREST Program Director and other team members to secure additional funding to support the provision of CREST services for persons with hoarding disorder were ongoing at the time of preparing this report.

Program Description

The County of San Diego Health and Human Services Agency's (HHSA) Behavioral Health Services (BHS) CREST program was funded through the Innovations (INN) component of the Mental Health Services Act (MHSA). CREST was designed to reduce hoarding behaviors among adults age 60 and older through a unique treatment approach that integrated cognitive training and exposure therapy combined with care management, peer support, linkages to community services, and periodic in-depth assessments and evaluations to track progress. To facilitate engagement in and completion of the 26-session treatment program, services were provided in the participant's home. CREST services were provided by a team of UC San Diego psychologists, social workers, care managers, and peer support specialists.

Key innovations of the CREST program included the use of a structured in-home evidence-based cognitive training and exposure treatment. Another important innovation of CREST was the addition of a peer specialist with successful prior hoarding disorder treatment experience to provide additional support to CREST participants. CREST clinicians used a whole person approach, informing the treatment through a combination of both psychotherapy and care management. Through the combined effect of the treatment sessions, peer specialist support, and comprehensive care management, CREST participants were expected to reduce their hoarding behaviors, resulting in improved mental health, well-being, housing stability, and safety.

Service Changes Due to COVID-19

The COVID pandemic first affected the San Diego area in a substantial manner during March 2020. San Diego County issued a public health order effective 3/13/2020 to limit the size of public gatherings to less than 250 persons and to restrict access to hospitals and long-term care facilities serving seniors. This was followed by a statewide public health order on 3/19/2020 that required all non-essential workers to stay at home. During this time period San Diego County BHS programs had to quickly adapt to the new service

delivery environment to protect both client and staff safety while continuing to provide mental health services. For many programs, these changes included a switch to or greater utilization of telemental health services.

With the onset of the COVID-19 pandemic, CREST suspended in-person visits with participants and transitioned to primarily phone and, where possible, video visits. This allowed the program to maintain contact with participants and continue with ongoing treatment activities, even if not as preferable as conducting in-home, in-person visits. Where relevant, findings and recommendations in this report indicate issues potentially related to the unique challenges that COVID-19 poses within the local community and healthcare environment.

Program Screening, Eligibility, and Enrollment

Throughout the CREST program (i.e., FY 2015-16 to FY 2019-20), a total of 504 persons were screened for eligibility. Of these, 446 (88.5%) were determined to meet criteria for hoarding disorder. Persons typically also needed to have Medi-Cal insurance (including those dually enrolled in both Medi-Cal and Medicare), or be uninsured and eligible for Medi-Cal insurance to enroll into the CREST program. While some case-by-case exceptions were allowed, this requirement was intended to keep the focus of CREST services primarily on the low income populations served by County-funded "safety net" behavioral health services.

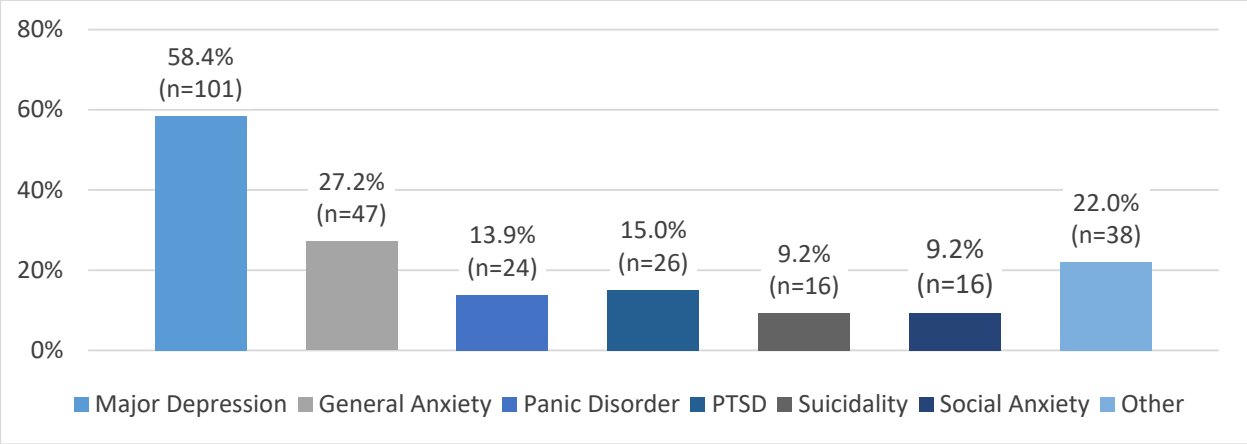
In addition, CREST initially began as a pilot program with specific geographic boundaries that restricted eligibility to select zip codes. However, the high number of persons identified by CREST as having hoarding disorder in other areas of San Diego County and preliminary success of the program prompted a countywide expansion during FY 2018-19. Overall, a total of 173 unique persons met all eligibility criteria and enrolled into the CREST program (i.e., 38.8% of the 446 determined to exhibit signs of hoarding disorder). Having income that exceeded Medi-Cal thresholds was the primary reason that persons identified with hoarding disorder were unable to enroll into CREST.

Participant Characteristics

A brief overview of the CREST participant characteristics is presented here with a more complete listing in the appendix. A total of 173 participants enrolled into the CREST program between FY 2015-16 and FY 2019-20. The average age of enrollees was 69.2 years. The majority of participants were female (68.8%; n=119), spoke English as their primary language (91.9%; n=159), and identified as heterosexual (77.5%; n=134). Approximately 10% (9.8%; n=17) reported they had previously served in the military. Over half of the participants identified as White (75.7%; n=131). Overall, 76.9% (n=133) of participants received some form of post-high school education. Asked to indicate a disability that was not the result of a serious mental illness (SMI), 72.2% (n=125) of participants indicated having a disability, with 37.6% (n=65) reporting a physical disability and 27.7% (n=48) reporting a chronic health disability.

As shown in Figure 1, CREST participants were also frequently diagnosed with other mental health conditions in addition to their hoarding diagnosis. The most common diagnoses were major depression (58.4%; n=101) and general anxiety (27.7%; n=47). Overall, almost 80% (79.8%; n=138) had at least one other mental health diagnosis.

Figure 1. Prevalence of Comorbid Mental Health Diagnoses (N=173)



Note: Total may exceed 100% since more than one mental health diagnosis could be selected.

Participant baseline responses to the Hoarding Rating Scale (HRS) questions indicated substantial negative effects on the lives of many CREST participants due to clutter in their home. Of the 143 who completed the HRS, 59.4% reported severe to extreme difficulty using rooms in their house, 60.1% reported severe to extreme clutter-related emotional distress, and 68.5% reported severe to extreme impairment in their life. These findings indicate that the majority of the persons who enrolled into CREST had very significant and serious negative implications on their well-being due to their hoarding related behaviors.

As shown in Table 1, baseline responses to the Homelessness Risk Screener (n=135), indicated that many CREST participants had risk factors for homelessness in addition to any hoarding-related home condition concerns.

Table 1. Homelessness Risk Factors of CREST Participants (N=135)

%	Homelessness Risk
35.6%	Ever homeless/not have a home of own
35.6%	Have poor credit history
56.3%	Without somewhere to stay/without plan for housing if lost current housing
65.2%	Have at least one barrier to getting or keeping their home, including: lack of employment (19.3%), lack of transportation (27.4%), and lack of financial assistance (40.0%).

Primary Program Outcomes

Reductions in Hoarding Behaviors and Impairment

Upon entering the CREST program and upon the time of program completion (n=104) participants would complete the Hoarding Rating Scale (HRS). This 5-item scale asks participants to rate the extent to which they experience each hoarding related behavior or impairment on a 9-point scale ranging from 0 (not at all) to 8 (extremely). As shown in Table 2, the reduction for each hoarding related item was statistically significant and substantially less of a problem following the completion of the CREST program. The overall

average rating was significantly reduced from 5.0 (moderate/severe) at baseline to 2.9 (mild/moderate) at the end of the program.

Table 2. Participant Hoarding Rating Scale (HRS) at Baseline and Post CREST Completion (N=104)

Hoarding Behavior Effects ***(Note: each item rated from 0 to 8 with higher values indicative of more serious hoarding behaviors)***	**Baseline**	**Post CREST**
1. Because of the clutter or number of possessions, how difficult is it for you to use the rooms in your home?	4.9	3.0*
2. To what extent do you have difficulty discarding ordinary things that other people would get rid of?	5.1	3.0*
3. To what extent do you currently have a problem with collecting or buying more things than you can use or can afford?	4.2	2.0*
4. To what extent do you experience emotional distress because of clutter, difficulty discarding or problems with buying or acquiring things?	5.2	3.3*
5. To what extent do you experience impairment in your life because of clutter, difficulty discarding, or problems with buying or acquiring things?	5.4	3.2*
Average HRS Score	**5.0**	**2.9***
Total HRS Score (mean / median)	**24.8 / 25**	**14.4* / 14**

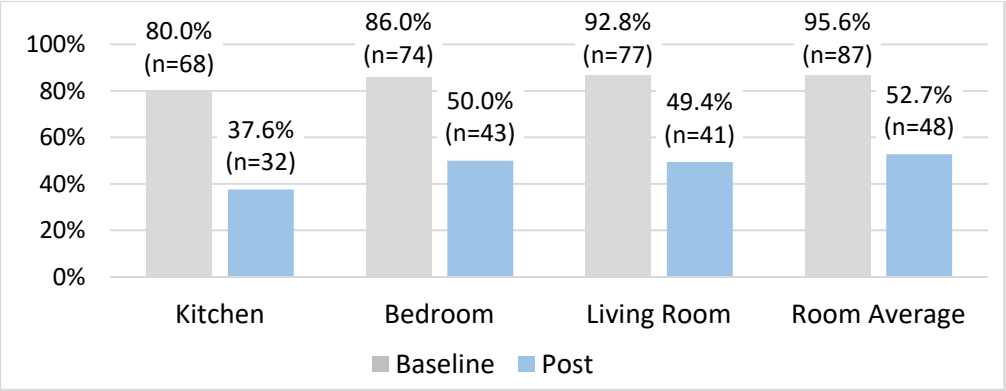
**statistical significance at p < 0.001*

An HRS total score of more than 14 is considered to indicate a person with clinically significant hoarding. As expected, CREST program participants exhibited significant problems with hoarding when entering the program showing an average baseline HRS total score of 24.8. Whereas upon completing the CREST program the average HRS total scores dropped to 14.4, with a median of 14. This indicates that many persons had reductions in their hoarding behaviors and 50% of the participants no longer exhibited clinically significant hoarding after completing the CREST program.

Reductions in Clutter

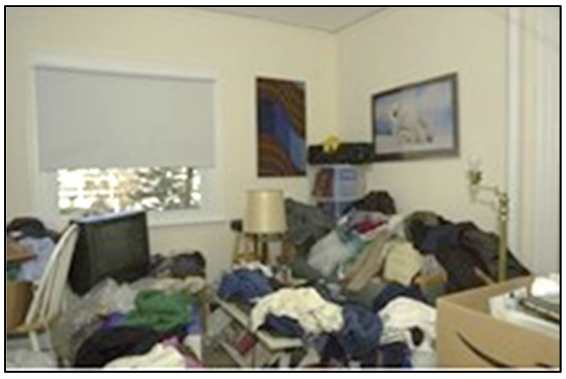
The Clutter Image Rating (CIR) scale is a tool used to rate clutter levels on a scale from 1 to 9 (most cluttered = 9) by selecting the image that most closely resembles someone's living spaces (i.e., kitchen, living room, bedroom; see example CIR images below). Figure 2 presents the percentage of participants who had a CIR value **greater than 2** before or after treatment (mean CIR values listed below the chart). Of participants with CIR ratings at both time points (n = 94), substantially fewer had CIR values greater than 2 after receiving CREST treatment services. Mean CIR scores significantly decreased as well for each room individually and the overall room average decreased from 4.5 to 2.7. These findings of decreased clutter were consistent with improved symptom management due to CREST program participation.

Figure 2. Percent of Participants with Clutter Image Ratings Greater than Two (N=94)

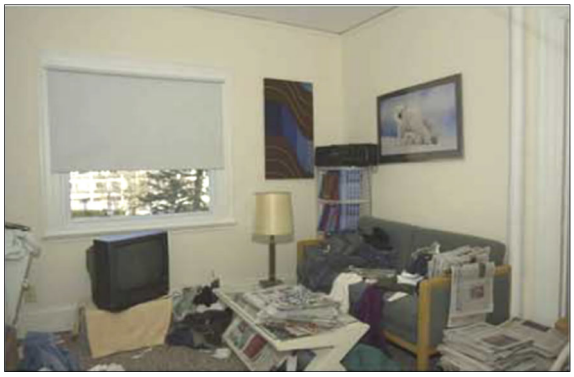


	Kitchen		Bedroom		Living Room		Room Average	
Mean Clutter Image Rating	4.0	2.4*	4.7	3.1*	4.9	3.0*	4.5	2.7*

**statistical significance at p < 0.001*



CIR Living Room Rating #5



CIR Living Room Rating #2

Reductions in Homelessness Risks

Upon entering the CREST program, participants completed the Homelessness Risk Screener designed to assess their personal risk for homelessness. Questions included such items as asking participants about their current and past living situations, the types of environments they have lived in, if they rely on family for financial support, and what types of barriers they face when it comes to housing stability. This same questionnaire was then completed again when participants completed the program.

Overall, there were fewer participants who were at risk for homelessness after completing the CREST program. In particular, 22.1% (n=21) of the 95 participants who completed the Current Homelessness Risk Screener were either homeless, living in temporary housing, or facing eviction/legal issues related to housing upon entering CREST, whereas only 11.6% (n=11) indicated these conditions after completing the CREST program. Likewise, at baseline 18.9% (n=18) reported receiving complaints from landlords and/or being contacted by public officials (i.e., code enforcement) about the condition of their home in the past 30 days. After completing CREST only 6.3% (n=6) indicated they had experienced those situations. CREST

also reduced future risk of homelessness by helping participant plan for alternative arrangements if for some reason they did need to move. Almost two-thirds (64.2%; n=61) indicated at baseline that they had no plans or place to go if they lost current housing, but that reduced to 41.1% (n=39) after completing CREST.

Additionally, CREST team members prevented 25 evictions from occurring to CREST participants. This frequently involved extensive coordination between participants, property owners/managers, and/or code enforcement to quickly develop and implement an effective remediation plan that would allow the participants to retain their housing. Where appropriate, CREST also helped participants identify and move into new housing that was more appropriate and sustainable.

The participant self-reported findings coupled with the actions of the CREST program indicate that actual homelessness and risks for homelessness were successfully eliminated or reduced for many CREST participants.

Reductions in Fall Risk

Participant responses to the Activities of Daily Living in Hoarding (ADL-H) scale at baseline and after completion of the CREST program provide evidence of reduced fall risks. In particular, average ratings (n=100) for the item "Move around inside the house" decreased significantly from 2.8 (little/moderate difficulty) at baseline to 1.8 (easily/little difficulty) following CREST program completion.

Reductions in Depression and Anxiety

Depression and anxiety are common among persons with a hoarding diagnosis (as reported above by the high prevalence of comorbid major depression (58.4%) and anxiety (27.2%) among CREST participants). To assess the extent to which CREST was successful at mitigating these additional behavioral health concerns, participants completed the 15-item Geriatric Depression Scale (GDS) and 30-item Geriatric Anxiety Scale (GAS).

The GDS includes 15 "Yes/No" type questions such as "Do you often feel helpless?" and "Do you feel happy most of the time?" The GDS scores can range from 0 to 15 with a score greater than 5 suggestive of depression. Between FY 2015-16 and FY 2019-20, the 101 individuals who completed the GDS at baseline and after finishing CREST demonstrated a statistically significant mean score reduction from 7.1 to 4.7 and a median score reduction from 7 to 4. These GDS scores indicate that CREST participants typically exhibited evidence of depression when starting CREST, but not after completing the program. Of particular importance, at baseline only 40.8% of CREST participants indicated they were "basically satisfied with your life," whereas at the conclusion of CREST that percent rose to 66.3%.

Likewise, results from the GAS, showed reductions in anxiety among CREST participants. The GAS consists of 25 common symptoms of anxiety that are rated based on how frequently each symptom was experienced during the past week (i.e., a four-point scale ranging from "Not at all," "Sometimes," "Most of the time," to "All the time"). Total GAS scores can range from 0 to 75 with values higher than 16 indicative of clinical anxiety. The mean GAS total score reduced significantly from 24.1 at baseline to 16.5 at the completion of CREST (and median GAS reduced from 23 to 14) for the 98 participants with baseline and post-CREST GAS assessments. These changes suggest that anxiety was reduced for CREST participants, but challenges still remained for many even after completing CREST (e.g., a total of 72.4% demonstrated

GAS scores consistent with clinical anxiety at baseline compared to 42.9% at the end of the CREST program).

Examples of Clutter Reduction among CREST Participants

The CREST program was often able to make fundamental changes in the living environments of participants by partnering with them to collaboratively remove substantial amounts of clutter both within and outside of the home. These changes improved household safety and allowed for better access to and utilization of the space available to the participants. The photos below demonstrate the types of dramatic positive changes that CREST was able to accomplish.

Before Participating in CREST **After Participating in CREST**









Additional Program Activities

In addition to the treatment and case management services provided directly to CREST program participants, the CREST team demonstrated a sustained commitment to educating the community about hoarding, its symptoms, and how to care for persons with hoarding disorder. The CREST team conducted more than 380 hoarding related community education presentations that were attended by more than 4,000 people. The CREST program also developed a directory with more than 70 local services particularly relevant to meeting the needs of persons with hoarding disorder symptoms (e.g., code enforcement, meal services, home care supports).

The CREST program created training opportunities within their team to allow undergraduate and graduate students to learn more about providing hoarding disorder treatment services. The CREST team also provided specialized trainings to psychiatrists who served geriatric populations to improve their capacity to identify and treat persons with a hoarding disorder (e.g., hoarding disorder specific education about diagnostic indicators, symptom assessment, and home visit procedures/safety considerations).

As the CREST program expanded over time, the CREST team noted an increased need for language services, particularly among Spanish-speaking clients. Identifying an opportunity to increase access to available services and enhance patient-provider communication, the CREST treatment manual and all assessment materials were translated into Spanish and eight clients received services provided by Spanish-speaking therapists.

Primary Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings and 2) the Annual CREST Program Staff Survey. The stakeholder meetings were held periodically throughout the CREST program initiative with representatives from BHS, CREST, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual CREST Staff Survey was conducted yearly throughout the CREST program initiative to generate feedback about staff experiences with, perceptions about, and recommendations for program implementation and operations.

Key Characteristics of Typical CREST Participants

1. Persons who needed services for treating hoarding disorder were identified throughout all regions of the County.
2. Hoarding behaviors among clients were frequently evident for long periods of time (i.e., more than several decades).
3. Individuals with hoarding disorder were often socially isolated from family and friends and were generally not connected to other existing community resources.
4. Clients typically had multiple additional challenges beyond their hoarding diagnosis that needed to be addressed or accommodated during the treatment process including co-occurring physical, mental health (especially depression and anxiety), or substance abuse conditions, limited financial resources, lack of transportation, and social conflicts.
5. Clients often had relatively high levels of education (i.e., 76.9% had at least some college).
6. Many potential CREST participants with hoarding disorder were just above the income level for Medi-Cal, but still too impoverished to access the services they needed.

Participant Recruitment, Retention, and Engagement

1. Outreach to property managers and other community groups can help identify potential referrals.
2. Participants typically recognized that their hoarding behaviors had negative effects on their lives, which helped with initial motivation to enroll in CREST.

3. External pressures such as threats of evictions or failed health inspections provided additional motivation for clients to address hoarding behaviors, but can create challenges for the treatment team to respond to the urgency of such deadlines.
4. Prioritization of safety improvements and increased functionality of participants' homes provided tangible goals that helped with client engagement in services. Being able to see specific improvements/progress towards goals encouraged continued program participation.
5. Without proactive attention, common tendencies among participants can inhibit active engagement in treatment (e.g., reluctance to allow staff into home, not completing homework, full voicemails or lost phones, avoidance, lack of motivation or desire for change).

CREST Treatment Service Approach

1. Usage of manualized, evidence-based CREST program practices provided important overall structure for intervention delivery, however, flexibility in the application of the CREST treatment manual was needed to accommodate specific needs (e.g., language services) and circumstances of individual participants.
2. Given the difficulties of sustaining participant engagement throughout the 26-treatment sessions, Motivational Interviewing and the associated techniques to promote "buy-in" were identified as good supplements to CREST treatment services.
3. Where possible, family members and loved ones can be invaluable resources (e.g., referrals for treatment, emotional support, and help with maintenance of positive behaviors). It was also important to prepare and support family members through education and family groups.
4. In addition to family and friends, outreach to and education of other relevant service providers, such as landlords/property managers, code enforcers, and community members helped to implement collaborative, long-term solutions.
5. Providing "in-home" services was essential for program success by allowing the team to fully understand the extent of hoarding and any potential safety concerns. With the onset of COVID-19, services were still provided "in-home" via video calls where possible, and telephone when needed for existing clients.
6. Important to have access to supplemental funds in order to hire services that can address clients' physical and financial limitations (e.g., move large objects or pay for removal services/dumpsters), particularly when under the threat of eviction.
7. Reducing hoarding behaviors was often not easy or comfortable for participants.
8. Reduction of symptoms and impairments can be difficult for participants to maintain after treatment completion and may benefit from continued support in the form of booster sessions, aftercare groups, and referrals to community resources.
9. Some participants may need more than the current 26 sessions of the CREST program to achieve desired results. While typically demonstrating improvements, many persons completing CREST still met diagnostic criteria for hoarding disorder and would benefit from some additional long-term supports.

Multi-Disciplinary Team Approach

1. Comprehensive, "whole person" services were needed to address the multiple factors contributing to hoarding behaviors and the other challenging circumstances that many clients were experiencing. Providing such services required a team of persons with different skill sets and roles including clinicians, peer specialists, interns, and other support staff.
2. Team-based care required substantial attention to coordination and communication via regular supervision, team meetings, and consultations to promote seamless continuity of care.
3. Team members also needed to demonstrate a genuinely caring and empathetic orientation to those receiving CREST program services to promote trust and relationship building with participants.

Benefits of Including a Peer Support Specialist on CREST Treatment Teams

Peer Support Specialists (i.e., persons who had experienced similar issues with hoarding and had success addressing them), provided important emotional and practical supports to participants in their efforts to change hoarding behaviors. Key contributions of the Peer Specialist included:

1. Establishing a relationship with someone who can understand barriers/struggles better than anyone else.
2. Normalizing treatment program participation and potential feelings of shame and apprehension.
3. Providing emotional support.
4. Providing an example of success and hope for recovery.
5. Providing additional opportunities for client to practice skills (i.e., being present while client sorts and discards items).
6. Helping the process move forward through regular, more informal, check-ins.

Conclusion

A total of 173 persons enrolled into the 26-session specialized CREST treatment program for hoarding disorder between FY 2015-16 and FY 2019-20. The program started as a pilot program in a limited geographic area, but was expanded countywide during FY 2018-19 due to increased awareness of the high levels of need for hoarding treatment services throughout San Diego County. The multi-disciplinary team approach that consisted of therapists, care managers, and peer supports appeared to match well with the multi-faceted needs commonly evident among persons with hoarding disorder. Comorbid mental health conditions, other physical and brain disabilities, and chronic health concerns were frequently coupled with social isolation and limited economic resources available to obtain needed services.

Within these challenging contexts, the CREST care team was often able to develop the relationships and trust necessary to keep persons engaged in a comprehensive 26-session treatment program. The Peer Support Specialist, who was required to have had prior experience with successfully responding to hoarding disorder treatment, played an important role in providing additional emotional support and encouragement to the participants as well as more informal opportunities to practice skills learned in the therapy sessions.

As of 6/30/2020, a total of 104 persons had completed the entire program and the post-program assessments. The outcome data from the measurement tools indicated that the CREST program frequently achieved program objectives with participants demonstrating clinically significant reductions in: clutter, functional impairment, mobility impairments, homelessness risks, depression, and anxiety after completing the CREST program. In addition to these areas of improvement, the CREST program was also able to actively intervene and prevent 25 evictions from occurring within this vulnerable population by collaboratively developing and implementing plans with participants, property managers/owners, and where relevant, public entities such as code enforcement to mitigate issues prior to eviction.

While frequently demonstrating substantial improvements among persons who completed the CREST program, treating hoarding disorder remained a complicated endeavor that often required an extended period of time to enact desired changes. This was evidenced by the fact that, even if improved, some participants still met criteria for hoarding disorder and required additional treatment beyond the standard 26 sessions and/or would benefit from some form of aftercare (i.e., support groups), to minimize the risk of post-treatment relapse.

Future Directions

Although achieving clinically significant positive outcomes with many CREST participants, unanticipated budgetary limitations coinciding with the onset of COVID-19 pandemic resulted in a decision to not continue funding for the CREST program after the conclusion of the MHSA Innovations funding cycle on 6/30/2020. In an attempt to allow for these specialized treatment services for persons with hoarding disorder to continue in some capacity either locally in San Diego or other communities, the CREST Program Director and other affiliated team members have explored alternative funding sources. The efforts to secure additional resources to maintain provision of CREST services were ongoing at the time of preparing this report.

For more information about this Innovation program and/or the report please contact:
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Appendix

Participant Characteristics

Characteristic	Total Participants (N=173)	
Gender	N	%
Male	50	28.9%
Female	119	68.8%
Prefer not to answer/Missing	4	2.3%
Total	173	100%
Age Group	N	%
55-59	9	5.2%
>60	164	94.8%
Total	173	100%
Primary Language	N	%
English	159	91.9%
Spanish	8	4.6%
Other	6	3.5%
Total	173	100%
Race/Ethnicity	N	%
African American	7	4.0%
American Indian	10	5.8%
Asian	9	5.2%
Latino	14	8.1%
Caucasian/white	131	75.7%
Multi-racial	9	5.2%
Other/Missing	12	7.0%
Total[1]	-	-
Sexual Orientation	N	%
Heterosexual or straight	134	77.5%
Gay or lesbian	6	3.4%
Bisexual/Pansexual/Sexually fluid	5	2.9%
Another sexual orientation/Missing/Prefer not to answer	28	16.2%
Total	173	100%

Characteristic	Total Participants (N=173)	
Education	N	%
GED Coursework	11	6.4%
High school diploma/GED	27	15.6%
Some College/Some Technical or Vocational	56	32.4%
Associates Degree	25	14.5%
Bachelor's Degree	40	23.1%
Master's Degree and Above	12	6.9%
Missing	2	1.1%
Total	173	100%
Military Status	N	%
Never served in the military	143	82.7%
Previously served in the military	17	9.8%
Missing/Prefer not to answer	13	7.5%
Total	173	100%
Disability	N	%
Yes, Has a disability	125	72.2%
No, Does not have a disability	6	3.5%
Declined/Preferred not to answer	42	24.3%
Total	173	100%
Type of Disability	N	%
Seeing	24	13.9%
Hearing	21	12.1%
Learning	20	11.6%
Dementia	9	5.2%
Other Mental	12	6.9%
Physical	65	37.6%
Chronic Health	48	27.7%
Other	49	28.3%
Total[2]	-	-

[1] *Total may exceed 100% since more than one race/ethnicity could be selected.*
[2] *Since participants could select more than one specific non-mental health related disability, the percentages may total more than the percent who indicated having any disability.*



ACCESSIBLE DEPRESSION AND ANXIETY PERIPARTUM TREATMENT (ADAPT)

INNOVATIONS-18

Annual Report
Year 1 (7/1/2019 - 6/30/2020)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES (v.12.28.2020)

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO | UC San Diego

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Executive Summary

Program Overview

The County of San Diego Health and Human Services Agency's (HHSA) Behavioral Health Services (BHS) Accessible Depression and Anxiety Peripartum Treatment (ADAPT) program is funded through the Innovations (INN) component of the Mental Health Services Act. The ADAPT program was designed to improve access to treatment and address the negative health outcomes of perinatal mood and anxiety disorders, with a focus on women and families from underserved communities. A key component of the ADAPT program is the exclusive partnership with HHSA's Nurse Family Partnership (NFP) and Maternal Child Health Home-Visiting (MCH) programs to provide mental health services to clients. ADAPT provides therapeutic treatment, peer support, and linkage to community resources and support for the entire family in an in-home setting. With the onset of the COVID-19 pandemic, the ADAPT program suspended the practice of providing in-home assessments and clinical sessions and transitioned to providing these services via telephone or video where available. This allowed the ADAPT team to maintain continuity of care with minimal disruption to services; however, the number of referrals received from NFP and MCH decreased substantially as public health nurses were redirected to other COVID-19 related priorities.

Primary Findings for Fiscal Year (FY) 2019-20

1. The ADAPT program achieved substantial reductions in depression and/or anxiety symptoms and improved well-being among a significant number of participants.
2. Total ADAPT enrollment during Year 1 was less than the initial goal (i.e., 91 unduplicated persons compared to a target of 300). Key factors that contributed to lower than expected enrollment included: 1) initial program implementation challenges related to getting program and referral processes fully operational, 2) the onset of COVID-19 that dramatically reduced referrals from the NFP and MCH programs, and 3) fewer than expected partners and other family members enrolling in services. Additionally, the target of 300 served may need to be reevaluated in future years as a sizable portion of the client population persisted in the program for longer than the expected six months.

3. Good communication and coordination between ADAPT and public health nurses (PHNs) were critical to effective operations. Improved referral tracking processes and "roundtables" between ADAPT and PHNs helped to align expectations and practices.

Additional Program Highlights

1. Participant Characteristics
    a. A total of 91 participants enrolled in ADAPT during FY 2019-20.
    b. 98% of participants were female.
    c. 62.6% of participants identify as Hispanic/Latino.
    d. Approximately 40% of participants were between the ages of 16-25.
2. ADAPT Services
    a. Participants received, on average, 4.5 ADAPT services during each 30 days enrolled in ADAPT.
    b. 75.6% of ADAPT participants had at least one therapy session and 69.5% had at least one case management support visit.
3. Participant Outcomes
    a. Statistically significant improvements were seen across:
        i. Edinburgh Postnatal Depression Scale (EPDS)
        ii. Illness Management and Recovery-Reduced (IMR-R) scale
        iii. ADAPT Wellness Survey
4. ADAPT Participant Feedback
    a. 100% of participants indicated ADAPT staff were sensitive to their cultural backgrounds.
    b. 96.2% of participants indicated that they were satisfied with ADAPT services.
5. Partnership with Public Health Nurses
    a. Of the PHNs surveyed, 92.3% felt the ADAPT program provided important services to public health nursing clients.
    b. ADAPT staff provided a total of 589 PHN consultations to discuss the mental health needs of PHN clients.
    c. ADAPT staff conducted six training "roundtables" attended by a cumulative total of 72 PHNs.
6. Switch to Telehealth
    a. ADAPT staff indicated a high level of confidence in their ability to provide services via telehealth and recommended that telehealth services continue to be a priority even after resuming face-to-face visits.
    b. ADAPT staff estimated that less than 10% of clients were unable to consistently utilize telehealth with video due to problems with internet connectivity.

Conclusion

During FY 2019-20, the first year of ADAPT service provision, the program was able to successfully

establish Level-1 services (provided by licensed/license-eligible clinicians) and Level-2 services (provided by case managers) and demonstrate substantial reductions in participants' symptoms of distress as well as improvements in domains such as illness management, functioning, and quality of life. The onset of the COVID-19 pandemic required a shift away from in-person, in-home visits and substantially reduced referrals into the program, however, those receiving services indicated very high levels of satisfaction with ADAPT and the therapy, education, emotional support, and respect they received. As discussed above, overall enrollment was less than anticipated during FY 2019-20, so an emphasis in FY 2020-21 will be to better understand the reasons contributing to underutilization and to seek out opportunities to increase participation in ADAPT services.

Primary Recommendations for FY 2020-21

1. Identify additional sources of potential referrals, particularly while referrals from PHNs are reduced due to COVID-19.
2. Increase communication, coordination, and collaboration with PHNs.
3. Conduct record reviews to determine the extent to which ADAPT clients would qualify for Medi-Cal reimbursable services.
4. Examine Level-2 enrollment patterns to better understand why services were not utilized as much as anticipated.

ADAPT Program Description

The County of San Diego BHS ADAPT program is funded through the INN component of the Mental Health Services Act, with services provided by clinicians and staff from Vista Hill, a community-based nonprofit organization. ADAPT provides mental health services to clients of HHSA's public health NFP and MCH home visiting programs who have, or are at-risk of, perinatal mood or anxiety disorders. NFP is a free, voluntary program that provides at-home nurse visitation services to low-income, first-time mothers prior to their 28th week of pregnancy and continuing through the child's second birthday. Through NFP, PHNs provide support, education and counseling on health, behavioral and self-sufficiency issues. MCH is also a free, voluntary prevention program that provides at-home nurse visitation to at-risk, low-income, pregnant, and postpartum women and their children from birth to five years old. Similar to NFP, PHNs in the MCH program provide support, health and parenting education, address bonding issues, medical, and mental risks.

The ADAPT program was developed in response to concerns about the high prevalence of unmet treatment needs for perinatal anxiety and depression among the women served by the MCH and NFP programs and the desire to prevent the negative consequences often related to perinatal mood disorders, including challenges to the family unit, difficult infant temperament, and emotional and cognitive delays in children of mothers with perinatal mood disorders. ADAPT provides therapeutic treatment, peer support, and linkage to community resources and supports for the entire family. Services are evidence-informed and include care coordination and case consultation. To facilitate better access to care services, the program was designed primarily to provide in-home visiting. As discussed in more detail below, the

COVID-19 pandemic required ADAPT to shift their treatment approach from in-person visits to telehealth sessions. A key innovative component of the ADAPT program is the partnership between PHNs and the ADAPT mental health clinicians and peer supports. Additionally, ADAPT attempts to enhance the role of fathers/partners in therapeutic interventions as a way to reduce the symptoms of both maternal and paternal mental health disorders.

The ADAPT program was designed to provide two tiers of services. Level-1 participants included those who met criteria for specialty mental health services and peripartum criteria, evidenced in significant functional impairments, including but not limited to clinically significant depression and/or anxiety. The persons in Level-1 received ongoing therapy as well as other supportive services. Level-2 participants did not meet full criteria for specialty mental health services but demonstrated being at risk of perinatal mood disorders and anxiety based on assessment of biological, psychological, and social factors, and also demonstrated some impairments in functioning. These participants may have presented with less acute symptoms but were able to demonstrate risk and need for intervention to prevent development of functional impairments and maintain current functioning. Additionally, Level-2 included participants who would meet BHS eligibility for Level-1 services yet were receiving services from another mental health provider, reported not being interested in receiving mental health services at the time of initial assessment, or were able to receive mental health services from a private insurance provider. Persons in Level-2 could also include family members of Level-1 participants.

Service Changes Due to COVID-19

The COVID-19 pandemic first affected the San Diego area in a substantial manner during March 2020. The County of San Diego issued a public health order effective 3/13/2020 to limit the size of public gatherings to less than 250 persons and to restrict access to hospitals and long-term care facilities serving seniors. This was followed by a statewide public health order on 3/19/2020 that required all non-essential workers to stay at home. During this time period, County BHS programs had to quickly adapt to the new service delivery environment to protect both client and staff safety while continuing to provide mental health services. For many programs, including ADAPT, these changes involved a switch to, or greater utilization of, telehealth services.

The ADAPT program suspended the practice of providing in-home assessments and clinical sessions and transitioned to providing these services via telephone or video where available. In this way, the ADAPT team maintained continuity of care and experienced minimal disruption to services. In support of the PHN partners who experienced an increased demand for their services to directly address the COVID-19 pandemic in San Diego, the ADAPT team conducted additional wellness check-ins with PHN clients who were not ADAPT participants, but who might be experiencing additional stress during the challenging times. The number of referrals received from PHNs reduced substantially from an average of 22.1 per month pre-COVID-19 to 3.8 per month due to the additional COVID-19 related responsibilities that limited PHN availability. This contributed to the lower than expected FY 2019-20 enrollment totals (i.e., 91 unique persons enrolled compared to a target of 300 persons). A more detailed discussion of ADAPT experiences with providing telehealth services and the impact of COVID-19 on staff is included in other sections of the report.

Participant Characteristics

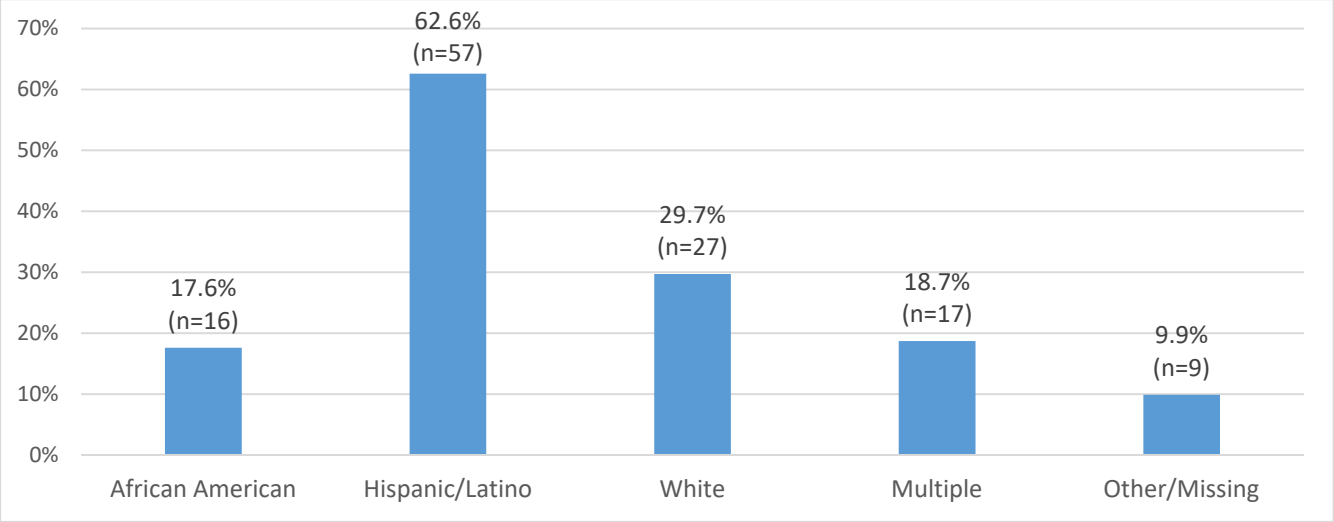
A brief overview of the ADAPT participant characteristics is presented here with a more complete listing in the appendix. As shown in Table 1, a total of 91 unique persons enrolled in the ADAPT program during FY 2019-20 (82 initial enrollments into Level-1 and 9 initial enrollments into Level-2). In addition to the nine persons who enrolled directly into Level-2, five persons transitioned from Level-1 to Level-2 during FY 2019-20 when they no longer had a need for ongoing clinical therapy services but still wanted the education and support services provided by ADAPT. These 91 persons enrolled into ADAPT during FY 2019-20 represent 89 different families with a total of 172 children in the households (including those not yet born at the time of ADAPT program enrollment).

Table 1. ADAPT Program Enrollment for FY 2019-20 (N=91)

	N
Level-1 services (i.e., ongoing therapy services)	82
Level-2 services (i.e., education and support services)	9
Total ADAPT enrollees	91

Across both service levels, 97.8% of participants identified as female (n=89). While the majority of participants indicated English as their primary language (69.2%; n=63), almost one quarter (24.2%; n=22) indicated Spanish as their primary language and were served by Spanish speaking ADAPT staff. Eighty-nine percent (n=81) of participants identified as heterosexual or straight. Participants were overwhelmingly between the ages of 16-35 (n=80; 87.9%), with only 12.1% (n=11) over the age of 36. As shown in Figure 1, the ADAPT program served a racial and ethnically diverse population with the majority of ADAPT participants identifying as Hispanic/Latino (62.6%).

Figure 1. Race/Ethnicity of ADAPT Participants (N=91)



Note: Total may exceed 100% since more than one race/ethnicity could be selected.

Utilization of Program Services

Level-1 Services

Based on data from the San Diego County BHS electronic health record system, Table 2 indicates the number and type of services provided by licensed and license-eligible clinicians on the ADAPT team for persons enrolled in Level-1 during FY 2019-20. The information indicates that during each 30 days enrolled in ADAPT, participants typically received approximately 4.5 ADAPT services (comprised primarily of an average of 1.9 assessment visits and 1.4 therapy visits per each 30 days enrolled in ADAPT). ADAPT offers family services for participants; however the majority of participants in Year 1 did not utilize family therapy. ADAPT services were also expected to directly and indirectly benefit the family unit through case management and resource support.

Table 2. ADAPT Level-1 Services during FY 2019-20 (N=82)

ADAPT Service Type	Persons with at least one service		Total ADAPT services provided	Average number of services per person, per 30 day period
	N	%		
Any ADAPT service	82	100.0%	1,593	4.5
Assessment/Tx. plan development	81	98.8%	468	1.9
Individual/Family therapy (i.e., by licensed clinician)	62	75.6%	655	1.4
Individual/Family rehab. (i.e., by peer support or other professional)	35	42.7%	85	0.2
Case management	57	69.5%	233	0.6
Other services (e.g., Collateral, Crisis intervention)	57	69.5%	152	0.4

The average time in the ADAPT program was 107.2 days (median of 87 days) for the 64 persons who had been discharged from Level-1 services prior to 6/30/2020; however, there was substantial variability among the participants. A quarter of these participants were in the program for less than one month (i.e., 28 days). These participants were classified by ADAPT staff as “discharged due to lost contact”, which includes the 20 participants who received an assessment but did not engage in individual or family therapy. A more detailed understanding of the reasons why some persons leave the program before fully engaging in services is needed to determine if ADAPT program practices can be adjusted to improve retention. On the other end of the continuum, a quarter of ADAPT participants were in the program for at least 176 days (maximum program duration of about one year). These findings indicate that while the typical ADAPT program duration was approximately three months, there was a substantial number of participants who required longer term services of six months or more, which required a program exception and approval from County of San Diego BHS.

Level-2 Services

A total of nine persons enrolled directly into Level-2 services, which were provided by case managers/peer support partners on the ADAPT team. An additional five persons transitioned from Level-1 to Level-2 services as a form of "step-down" in care since they no longer needed the more intensive therapy services provided in Level-1. These 14 persons received a total of 73 different Level-2 ADAPT service contacts during FY 2019-20. The Level-2 service contacts frequently focused on providing educational and/or skill-building opportunities. Self-regulation was the most common educational topic and occurred in almost half of the contacts (46.6%; n=34), followed by parenting skills (23.3%; n=17) and goal-setting (23.3%; n=17). Other services provided during these contacts included assistance with connecting to needed community resources (e.g., basic needs, physical health, housing, transportation, etc.).

Primary Program Outcomes

Due to the small number of Level-2 participants enrolled during FY 2019-20 and their differing service needs, participant outcomes referenced in this section of the report only include the 82 Level-1 participants.

Edinburgh Postnatal Depression Scale (EPDS)

The Edinburgh Postnatal Depression Scale (EPDS) is a 10-item self-report scale developed to identify individuals who may have postpartum depression in outpatient, home visiting settings, or at the 6-8 week postpartum examination in a physician's office. Individuals indicate which response comes closest to how they have felt over the previous seven days. Each item is scored on a 0 to 3 scale with higher scores reflecting worse condition/more distress. The maximum score is 30 and scores over 10 are considered to indicate likely depression. The EPDS was administered upon entry into ADAPT and then regularly thereafter as part of clinical assessment and treatment planning (i.e., re-administration of the EPDS was done more frequently than other evaluation measures discussed below due to its direct use as part of treatment).

As shown in Table 3, the average EPDS score at intake was 13.5, which reduced to 9.7 at the last EPDS follow-up assessment. This represents a statistically significant change in the total EPDS scores and reflects an overall reduction in symptoms as reported by ADAPT program participants. Additional analyses that compared the EPDS at intake to the EPDS administered closest to 30 days post-ADAPT enrollment found a statistically significant reduction to 11.9. This finding suggests that, on average, approximately half of the improvement in EPDS scores occurred within the first 30 days, with continued treatment leading to further improvements.

Table 3. Change in EPDS Scores from Initial Assessment to Last Follow-up Assessment (N=70)

		Initial EPDS	Last available EPDS
EPDS Item (Note: higher value = worse condition)	**N**	**Mean**	**Mean**
I have been able to laugh and see the funny side of things	70	0.7	0.6
I have looked forward with enjoyment to things	70	0.9	0.6^
I have blamed myself unnecessarily when things went wrong	70	2.0	1.4**
I have been anxious or worried for no good reason	70	2.1	1.5**
I have felt scared or panicky for no very good reason	70	1.7	1.1**
Things have been getting on top of me	70	1.7	1.4*
I have been so unhappy that I have had difficulty sleeping	70	1.4	1.0*
I have felt sad or miserable	70	1.5	1.2^
I have been so unhappy that I have been crying	70	1.2	0.8**
The thought of harming myself has occurred to me	70	0.3	0.1*
EPDS Total Score	70	13.5	9.7**
Likely Depression (i.e., score >=10)	-	54 (78.3%)	34 (48.6%)

*^statistical significance at p < 0.10; *statistical significance at p < 0.05; **statistical significance at p < 0.01*

An examination of the individual EPDS items indicates that improvements were generally evident across all dimensions. The items with the largest changes from intake consist of reductions in self-blame, anxiousness, and panic (i.e., absolute EPDS differences of 0.6). It is important to note that while thoughts of self-harm had a relatively low prevalence at intake (i.e., EPDS score of 0.3), this was an even more rare occurrence at follow-up as evidenced by a statistically significant reduction to 0.1. Overall, the findings demonstrated that ADAPT participants generally reported experiencing fewer symptoms of depression and anxiety after participating in the ADAPT program.

Illness Management and Recovery Scale-Reduced (IMR-R)

To measure clinician perceptions of client recovery and improved illness management, a shortened version of the Illness Management and Recovery-Reduced (IMR-R) scale was completed by ADAPT providers. The IMR-R included nine of the 15 items from the full IMR that were determined to be most relevant to the ADAPT program services and the focal service population (via review and consensus between representatives from ADAPT, BHS, and the evaluation team). Each item on the scale has a 5-point behaviorally-defined response option tailored to that specific domain. Items are rated from 1 to 5, with higher values indicating less impairment/better functioning. The IMR-R was administered upon entry into ADAPT and then at 90-day follow-up intervals, documenting the amount of potential initial impairment and extent to which changes may have occurred while receiving ADAPT services from the perspective of the ADAPT clinicians. As shown in Table 4, the initial IMR-R ratings varied substantially

across the individual items. While average ratings for many items were between 2-3 (generally indicative of moderate impairment), symptom distress was the lowest rated item at 1.7, which was indicative of fairly high levels of mental health-related distress upon entry into ADAPT. Conversely, domains that did not appear to be areas of concern at intake as determined by ADAPT providers included medication management or substance abuse (i.e., intake ratings ranged between 4 and 5). The overall IMR-R score at intake was 3.1.

Table 4. Change in IMR Scores from Initial Assessment to Last Follow-up Assessment (N=48)

		Initial Asmt.	Last Asmt.
IMR Item (Note: higher value = better condition)	**N**	**Mean**	**Mean**
Progress towards personal goals	44	2.7	3.6**
Knowledge about symptoms, treatment, coping strategies, and medication	48	2.8	3.5**
Involvement of family and friends in his/her mental health treatment	48	3.2	3.7**
Symptom distress	48	1.7	2.7**
Impairment of functioning	48	2.2	3.1**
Coping with mental or emotional illness from day to day	48	2.6	3.5**
Effective use of psychotropic medication	8	4.1	4.2
Impairment of functioning through alcohol use	45	5.0	4.9
Impairment of functioning through drug use	45	5.0	5.0
Overall	48	3.1	3.7**

***statistical significance at p < 0.01*

The overall IMR-R score increased from 3.1 to 3.7 at follow-up, which represented a statistically significant change and evidence of clinically meaningful improvements within the participant population. Among the individual items, medication management and substance use maintained their high values evident at intake (i.e., remaining as not areas of concern), while many of the gains for the other items approached or achieved a change score of 1.0. Of note, ratings of symptom distress improved from 1.7 to 2.7 at follow-up, which generally corresponds to a change from symptoms, on average, bothering clients "quite a bit" at intake to "somewhat" at follow-up. The results from the reduced IMR-R indicated the achievement of important improvements with minimizing symptom distress and impairment, while also increasing knowledge, coping skills, and involvement of family to help maintain benefits and minimize risks of future recurrence of symptoms.

Wellness Survey Questionnaire

The ADAPT Wellness Survey is a self-report tool completed by the ADAPT participant. This tool was administered upon enrollment into ADAPT and then every 90 days thereafter. Unless otherwise noted, all survey items were rated on a scale from 1 to 5, with higher values representing the better or more desirable response. As shown in Table 5, self-reported improvements occurred across multiple dimensions including quality of life, mental health, social relationships, and hopefulness for the future.

These areas of improvement were consistent with the primary areas of emphasis within the ADAPT program.

Table 5. Change in Wellness Survey Scores from Initial to Last Follow-up Assessment (N=48)

		Initial Asmt.	Last Asmt.
Wellness Survey Item (Note: higher value = better condition; Scale of 1 to 5)	**N**	**Mean**	**Mean**
In general, would you say your health is:	48	2.9	3.1
In general, would you say your quality of life is:	47	3.1	3.4*
In general, how would you rate your physical health?	48	2.8	2.9
In general, how would you rate your mental health, including your mood and your ability to think?	48	2.4	2.7**
In general, how would you rate your satisfaction with your social activities and relationships?	48	2.5	2.9*
In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.).	48	2.9	3.2^
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	48	3.9	4.4**
How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	48	2.3	2.7*
My child(ren) had emotional and/or behavioral problems.	36	4.6	4.3
I believed people were following or trying to harm me or my family.	38	4.9	5.0
I heard voices that no one else could hear.	38	4.9	4.8
I felt hopeful about the future.	38	3.3	3.9**
I felt spiritually connected.	38	3.0	3.5^
I lived in a home that made me feel safe.	38	4.3	4.6
I used substances (alcohol, illegal drugs, etc.) too much.	38	4.8	4.9
How would you rate your fatigue on average?	48	3.1	3.2
Scale of 0 to 10; Higher value = worse condition	**N**	**Mean**	**Mean**
How would you rate your pain on average?	48	3.1	3.2

*^statistical significance at p < 0.10; *statistical significance at p < 0.05; **statistical significance at p < 0.01*

ADAPT Participant Feedback Survey

Every 90 days (and at discharge), ADAPT program participants were asked to complete a survey regarding their perceptions of the ADAPT program and the extent to which they thought participation in ADAPT resulted in achieving general objectives of knowing where to get help, increased comfort in seeking help (i.e., stigma reductions), and overall ability to handle things. As shown in Table 6, over 90% of participants indicated that they knew where to get help and were more comfortable seeking help as a result of receiving ADAPT services and approximately 85% (84.6%) indicated that they were better able to handle things. Overall, participants in ADAPT services were extremely positive about their experiences. Over 90% indicated that ADAPT services were available at convenient times (94.2%), that they were able to obtain all needed services (92.3%), that staff were sensitive to cultural background (100%), and that they were satisfied with ADAPT services (96.2%). These findings, particularly as related to service availability and cultural support, indicate that the ADAPT program has accomplished the goal of connecting with participants and meeting their needs in a manner which is convenient for and respectful of the participants.

Table 6. ADAPT Program Feedback Survey (N=52)

ADAPT Program Feedback Survey Item	Agree/ Strongly Agree	
As a result of participating in ADAPT:	**N**	**%**
I know where to get help when I need it.	49	94.2%
I am more comfortable seeking help.	47	90.4%
I am better able to handle things.	44	84.6%
Experiences with ADAPT services:	N	**%**
Services were available at times that were good for me.	49	94.2%
I was able to get all the services I thought I needed.	48	92.3%
Staff were sensitive to my cultural background (race, religion, language, etc.).	52	100.0%
Overall, I am satisfied with the services I received here.	50	96.2%

Participants were also asked what they thought were the most important benefits or services received through their participation in ADAPT. The following quotes from the open-ended responses reflect typical content and tone of the comments:

"Helped me get out of dark deep hole I felt at start of postpartum. Thanks to this program I am no longer there."

'"Emotional support and guidance. Understanding life a little better. I love my therapist's passion and dedication to my individual needs."

"For me and my child, feel more secure with being a mom."

"The most important benefit was having [the therapist] come into our home to provide therapy to the whole family. It really helped us connect with each other."

"The resources, as there were so many and also the support & encouragement. So flexible and helpful to not leave [home]."

A review of the responses indicated the following four primary types of ADAPT service benefits:

1. Learning about mental health issues and the techniques to better manage/prevent symptoms.
2. Receiving general emotional support and encouragement from therapists/peer support partners.
3. Opportunity to have someone to talk to/with which to have positive social interactions.
4. Assistance with obtaining tangible community resources (e.g., food stamps).

Within these responses, participants also identified two key factors that facilitated their engagement in the ADAPT services:

1. Positive and trusting relationships with ADAPT therapists and peer support partners.
2. Convenience of participating in services via home visits (pre-COVID) or telephone/video calls.

When asked for recommendations to improve ADAPT program services, many indicated that they did not have recommendations since they were generally happy with the services received. The most common specific recommendation was to request that they could continue receiving ADAPT services for a longer period. Another recommendation was to allow for additional forms of communication with the ADAPT team, such as texting. After the onset of the COVID-19 pandemic, some participants indicated that they wished they were able to have in-person meetings in addition to the remote contact telephone and video call options. As a whole, the recommendations generally reflected an interest on the part of ADAPT participants for extended and/or enhanced communication and interaction with ADAPT program team members.

Public Health Nurse Feedback Survey

As an important ADAPT program partner, a brief online survey was conducted with PHNs to obtain feedback regarding their experiences with the ADAPT program. PHNs were asked to indicate the extent to which they agreed with a series of statements on a 5-point rating scale ranging from "strongly disagree" to "strongly agree". For the qualitative open-ended survey questions seeking PHN feedback and recommendations, at least two evaluators reviewed and coded the individual survey responses and any discrepancies were discussed to arrive at a consensus on the key response themes. A total of 26 PHNs completed the survey. As shown in Table 7, PHNs almost universally agreed (92.3%; n=24) that the ADAPT program provided important services to their clients. PHNs indicated they often observed client improvements such as increased confidence and hope, better decision-making and overall mental well-being, and additional connections to needed community resources. PHNs commented that they found the collaboration with ADAPT helpful and complementary to their services.

Table 7. PHN Reponses from ADAPT Program Feedback Survey (N=26)

ADAPT Program Feedback Survey PHN Responses	Agree/Strongly Agree	
Item	**N**	**%**
The ADAPT program provides important services to public health nursing clients.	24	92.3
I am confident that I can identify appropriate ADAPT program referrals.	20	76.9
It is easy to connect potential referrals to the ADAPT program.	16	61.5
Overall, I am satisfied with the partnership with the ADAPT program.	19	73.1

Approximately three-quarters (76.9%; n=20) indicated that they were confident identifying potential clients for ADAPT services and 61.5% indicated that it was easy to connect clients to the ADAPT program. Respondents indicated that mental health "roundtable" trainings conducted by ADAPT staff were helpful to the PHNs. Additional trainings related to mental health and mental health assessments were of interest to PHNs as this would allow them to further increase their capabilities and confidence in identifying persons who would likely benefit from ADAPT services.

Coordination and communication activities between ADAPT and the PHNs evolved throughout FY 2019-20, with a particular emphasis on improving the initial referral process. Initial referral efforts by PHNs were found to be challenging, and substantial effort was made by PHNs, ADAPT staff, and County of San Diego BHS to build a sustainable partnership. Recommendations from PHNs included additional options for submitting referrals, such as via secure email. Given the additional responsibilities for PHNs with the onset of the COVID-19 pandemic, PHNs acknowledged that there was less time to focus on the ADAPT partnership, which resulted in a reduced flow of referrals into ADAPT. Some PHNs expressed appreciation that ADAPT provided extra services during the pandemic to PHN clients who needed additional supports due to the challenging circumstances. Overall, 73.1% (n=19) indicated that they were satisfied with the partnership with ADAPT.

Additional Program Activities

Training and Consultation with PHNs

In addition to the direct services offered to Level-1 and Level-2 ADAPT participants, ADAPT staff provided a total of 589 PHN consultations to discuss the mental health needs of their clients. ADAPT staff also collaborated with PHNs to conduct 38 case conferences during which specific treatment and care strategies for assisting clients were reviewed. Case conferences are scheduled meetings of PHN program which ADAPT staff attend to support education and consultation regarding client cases.

To increase PHN awareness and understanding of mental health issues, ADAPT staff conducted six training "roundtables" that were attended by a cumulative total of 72 PHN (note: PHNs could have attended multiple trainings). Roundtable trainings are offered by ADAPT to PHNs and are typically facilitated by the ADAPT clinical supervisor and/or Program Manager. The focus of the roundtable varies based on requests from PHNs. Topics covered in FY 2019-20 included programmatic support, support for nurses struggling with staff changes, trauma-informed language to use with clients, what success can look like for PHN meetings, and self-care.

Feedback from these roundtables indicated that nurses appreciated this time to reflect on their experiences with and offer recommendations for the ADAPT partnership. Many of these roundtables have included assistance with understanding ADAPT services and eligibility requirements as PHNs reported some challenges with identifying appropriate referrals. Unfortunately, case conferences and ADAPT-led trainings of PHNs were suspended due to the onset of the COVID-19 pandemic and the additional demands that were placed on PHNs as part of the local frontline response. This likely reduced the total number of case conferences and trainings that otherwise would have been provided during FY 2019-20.

Outreach and Support to PHN Clients during COVID-19 Pandemic

With the onset of the COVID-19 pandemic, ADAPT offered to conduct outreach and support sessions to PHN clients who were not enrolled in ADAPT, but who might be experiencing additional stress related to COVID-19 and/or the community response to it (e.g., stay-at-home orders, difficulties obtaining needed supplies, disruptions to employment and schooling, etc.). As of 6/30/2020, ADAPT providers had conducted a total of 16 such sessions with 13 different PHN clients.

These sessions served to support PHN clients while PHNs were responding solely to COVID-19 specific public health needs and duties. Many of these services included case management and general well-being check-ins due to PHNs having less availability to attend to such needs.

Primary Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings and 2) the Annual ADAPT Staff Survey. The stakeholder meetings were held throughout the year with representatives from BHS, ADAPT, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual ADAPT Staff Survey was conducted at the end of FY 2019-20. ADAPT program staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. There were 10 respondents from the 13 ADAPT staff invited to participate in the survey for a 76.9% response rate. For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses and any discrepancies were discussed to arrive at a consensus on the key response themes.

PHN and ADAPT Program Collaboration and Communication

As with many new initiatives, especially those with multiple organizational partners, mutual learning between the ADAPT program and the PHNs was required in order to develop, implement, and refine the coordination of information and services. Overall, ADAPT staff indicated that improving communication with PHNs would help achieve program goals. While not feasible after the pandemic, periodic face-to-face interactions with the PHNs was identified as an effective strategy to better coordinate PHN and ADAPT activities. Overall, PHNs had reduced availability to interact with the ADAPT program after the emergence of COVID-19. Two components of the relationship between PHNs and ADAPT that were of particular importance during FY 2019-20 included: 1) the identification of potential ADAPT referrals and 2) communication of referrals from PHNs to the ADAPT program.

PHN Identification of Potential ADAPT Participants

Potential ADAPT participants were not recruited directly by ADAPT, but were identified by PHNs and then referred to the ADAPT program for eligibility determination. As noted above, responses from the PHN feedback survey suggest that about 75% of PHNs felt confident at the end of FY 2019-20 that they could identify appropriate referrals for ADAPT. This has been an area of emphasis and progress throughout FY 2019-20. Trainings designed to increase PHN awareness and understanding of mental health issues coupled with ongoing review and feedback about PHN referrals helped to improve the fit between PHN referrals and ADAPT program eligibility criteria. Additionally, individuals screened may have had an interest in talking with someone to help them with difficult days but were unsure about enrolling into a formal mental health treatment program, even the more generalized Level-2 services. ADAPT staff recommended further education and communication with PHNs to support their efforts to identify ADAPT program referrals.

Referral Process from PHNs to ADAPT Program

A crucial aspect of PHN and ADAPT program coordination involved the process of submitting referrals of PHN clients identified as potential ADAPT candidates to the ADAPT program. Key steps in the referral process included the development of referral documents that met the needs of both sets of users and protocols to guide the process of submitting and tracking status of referrals. As a result of ongoing discussions, the referral documents and process were revised multiple times during FY 2019-20, which facilitated more efficient and effective communication. In January 2020, ADAPT implemented a shared referral tracker that provided the disposition of referrals to each public health region. This referral tracker was shared weekly via email and has improved communication between PHNs and ADAPT.

Of note, the number of referrals from PHNs to the ADAPT program reduced substantially following the onset of the COVID-19 pandemic and remained very low as of 6/30/2020 (i.e., reduced from an average of 22.1 to 3.8 per month pre- and post-pandemic, respectively).

ADAPT Participant Engagement and Retention

ADAPT staff reported that maintaining client active engagement in services and/or retaining clients in services was not a major challenge for the program. Staff cited the convenience of services (i.e., in-home services and flexible scheduling) as a factor that helped keep clients engaged as well as the positive relationships with ADAPT therapists and peer support partners. ADAPT staff recommended increasing communication options (i.e., text and e-mail) as an effective strategy for increasing communication with clients and further supporting their active engagement in services.

One aspect of the ADAPT program that did not develop as anticipated during FY 2019-20 was the involvement of substantial numbers of male partners and/or other family members in ADAPT services. While some clients indicated that there were indirect benefits for the broader family unit such as improved communication skills, direct participation in ADAPT services by persons other than the mothers was rare. ADAPT staff indicated that this situation could be due, in part, to perceived reluctance on part of male partners/other family members as well as to some potential hesitation on the part of the mothers to involve others as they valued the time to focus specifically on their personal experiences and needs.

Experiences with Telehealth Services

With COVID-19, the ADAPT program was required to shift from providing primarily in-person, in-home services to only interacting with clients "virtually" via telephone or video telehealth calls. When asked to compare experiences between in-person and telehealth services, ADAPT providers indicated both approaches were equally effective for maintaining client engagement and focus during sessions, enabling quality communication, and openness of clients to share personal information. Providers indicated that telehealth might actually be slightly better for maintaining relationships with clients. In general, ADAPT staff indicated a high level of confidence in their ability to provide services via telehealth, and thought that telehealth should remain a priority for the program even after in-person services become safe and available again. In this regard, a mixture of in-person and telehealth services was considered to be ideal.

A key benefit of the greater use of telehealth services was the substantial amount of time saved by not having staff travel throughout the entire County to provide the in-home services. Additionally, the switch to telehealth services facilitated a more efficient allocation of staffing resources to meet client needs throughout the County rather than maintaining primarily region-based service teams, particularly when needed to cover any staffing gaps due to turnover or leaves of absence.

According to ADAPT staff, less than 10% of clients were unable to consistently utilize telehealth with video due to problems with internet connectivity or other technical challenges managing video calls. Staff indicated that issues with providing telehealth video calls were generally diminishing by the end of FY 2019-20 as comfort and expertise on the part of both clients and providers increased. Staff highlighted the importance of setting clear expectations with how to conduct telehealth with video sessions and establishing a pre-arranged plan for if and when a connection was lost (i.e., telephone follow-up). Additional recommendations would be to provide options for internet access and/or devices to facilitate telehealth video sessions. Even when video calls were possible, staff estimated that approximately 10-20% of clients preferred telephone only sessions. While telephone may be perceived as more convenient by some clients, ADAPT staff encouraged video calls as much as possible.

Impact of COVID-19 on ADAPT Staff

ADAPT staff indicated that COVID-19 nearly universally changed their work settings with the transition away from in-person services provided at the homes of ADAPT clients to telehealth services provided primarily from the homes of ADAPT personnel. Staff also reported substantial changes in their lives unrelated to work due to COVID-19 and most indicated experiencing additional stress and anxiety. Staff used self-care and social connections to help manage or reduce COVID-19 related stress or anxiety.

Program Changes from Initial Design

Non-COVID Related Changes

While there were ongoing administrative and programmatic adjustments that occurred throughout FY 2019-20, there were no substantial changes from initial program design unrelated to the COVID-19 response (i.e., transition to telehealth). As noted above, however, one aspect of the program that did not materialize as anticipated was the inclusion of substantial numbers of male partners and/or other family members in ADAPT services. Such services will continue to be offered in future years.

Program Recommendations

1. Identify additional sources of potential referrals, particularly while referrals from PHNs are reduced due to COVID-19.
2. Increase communication, coordination, and collaboration with PHNs.
3. Increase allowable communication methods with clients (e.g., texting and email).
4. Improve administrative efficiencies (i.e., review of referral, intake, and evaluation practices).
5. Conduct record reviews to determine the extent to which ADAPT clients would qualify for Medi-Cal reimbursable services.
6. Examine Level-2 enrollment patterns to better understand why services were not utilized as much as anticipated.
7. Generate a more detailed understanding of the reasons why some persons leave the program before fully engaging in services.
8. Promote community education of peripartum behavioral health.
9. Explore development of a County designated "Peripartum Warm Line" that can be called when needed to provide support during challenging times that do not require a crisis/emergency response.

Conclusion

During FY 2019-20, the first year of ADAPT service provision, the program enrolled a total of 91 persons. Factors that contributed to lower enrollment than anticipated (i.e., the initial goal was 300 persons per year) included: 1) initial program start-up challenges related to establishing and implementing program operations and aligning PHN referrals with ADAPT eligibility criteria, 2) receiving very few referrals from PHNs following the onset of the COVID-19 pandemic, and 3) lower than expected enrollment of partners and other family members into ADAPT services. The ADAPT program will continue to explore options during FY 2020-21 to increase the number of enrollees.

The program was able to successfully establish the two tiers of ADAPT services with Level-1 for those who needed ongoing therapy and Level-2 for those who primarily needed psychoeducation and more generalized forms of supports. There were five persons who had a "step-down" in care needs and transitioned from Level-1 to Level-2. While service durations varied substantially among those discharged from Level-1 services, many were enrolled for approximately 3-4 months, but 25% of the client population remained in the program for at least 176 days.

As documented by both participant self-report and clinician-completed assessments, the ADAPT program demonstrated substantial reductions in symptom distress as well as improvements in multiple domains including illness management, functioning, and quality of life. Feedback from ADAPT participants about their experiences with the ADAPT program indicated high levels of appreciation for the services with the most common request for change being a recommendation to allow persons to stay in the program for a longer period of time. These findings indicate that the program has been able to achieve program outcomes and is well regarded by participants, even with the adjustment to telehealth services due to the

COVID-19 pandemic. Given the lasting impact of COVID-19 into at least FY 2020-21, an ongoing challenge for the ADAPT program will be to continue to adjust to service environment realities and seek out ways to enhance and support the relationship with PHNs while also exploring other opportunities to provide the much-needed treatment and/or education services to others throughout San Diego.

For more information about this Innovation program and/or the report please contact:
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Appendix

Characteristics of Participants who Enrolled during FY 2019-20

Characteristic	Total Participants (N=91)	
Gender	N	%
Female	89	97.8%
Another Gender Identity/ Missing/Prefer not to answer	2	2.2%
Total	91	100%
Age Group	N	%
16-25	34	37.4%
26-35	46	50.5%
>=36	11	12.1%
Total	91	100%
Primary Language	N	%
English	63	69.2%
Spanish	22	24.2%
Other/Missing/Prefer not to answer	6	6.6%
Total	91	100%
Race/Ethnicity	N	%
African American	16	17.6%
Latino	57	62.6%
Caucasian/white	27	29.7%
Multi-racial	17	18.7%
Other/Missing/Prefer not to answer	9	9.9%
Total[1]	-	-
Sexual Orientation	N	%
Heterosexual or straight	81	89.0%
Bisexual/Pansexual/Sexually fluid	6	6.6%
Missing/Prefer not to answer	4	4.4%
Total	91	100%
Military Status	N	%
Never served in the military	88	96.7%
Other/Missing/Prefer not to answer	3	3.3%
Total	91	100%

Characteristic	Total Participants (N=91)	
Disability	N	%
Yes, Has a disability	15	16.5%
No disability/Declined/Prefer not to answer	76	83.5%
Total	91	100%
Type of Disability	N	%
Seeing/Hearing/ Other Communication	5	5.5%
Physical Disability/Chronic Health	7	7.7%
Other	9	9.9%
Total[2]	-	-

[1] *Total may exceed 100% since more than one race/ethnicity could be selected.*
[2] *Since participants could select more than one specific non-mental health related disability, the percentages may total more than the percent who indicated having any disability.*



BHCONNECT INNOVATIONS-19

Annual Report
Year 1 (7/1/2019 - 6/30/2020)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES (v.12.28.2020)

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO | UC San Diego

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Executive Summary

Program Overview

The County of San Diego Health and Human Services Agency's (HHSA) Behavioral Health Services (BHS) Telemental Health program (commonly known as BHConnect) focuses on persons who have received crisis-oriented psychiatric care services, but are otherwise unconnected to behavioral health treatment services. The goal is to reduce recidivism rates for psychiatric crisis services among these persons by offering an alternative method of care that relies exclusively on telehealth treatment. BHConnect provides clients with the technology necessary to maintain contact with telehealth professionals, such as a tablet or phone equipped with built-in internet access. As part of BHConnect, Welcome Home Health (WHH) services are available 24 hours a day/7 days a week to provide telehealth technical support, treatment scheduling reminders, follow-up for missed appointments, and to direct any crisis requests to appropriate services. Since the initial design of BHConnect already relied exclusively on the provision of mental health treatment services via telehealth technologies, BHConnect had essentially no disruptions to ongoing treatment services following the onset of the COVID-19 pandemic.

Primary Findings for Fiscal Year (FY) 2019-20

1. Overall, substantially fewer referrals than expected originated from referral partner agencies, which resulted in relatively low BHConnect enrollment for FY 2019-20 (i.e., 37 persons enrolled in the Children, Youth, and Family (CYF) BHS system and 17 persons enrolled in the Adult and Older Adult (AOA) BHS system).
2. Utilization of BHConnect services varied substantially within the youth and adult service populations. Approximately 15% of youth and 35% of enrolled adults did not participate in any BHConnect services (e.g., assessment, therapy, or case management); however, of those with any therapy services, the average number of sessions received was 6.9 and 9.9 for youth and adults, respectively as of 6/30/2020. Almost 65% of the enrolled youth and 40% of adults had at least 3 therapy sessions.
3. The BHConnect staff reported that successful client recruitment of persons previously unconnected to services was facilitated by key program components such as offering clients a dedicated device for telehealth services, providing crisis coverage through telehealth services 24 hours a day/7 days a week

via the WHH partnership, and enabling clients to quickly start services (i.e., not being put on a program waitlist).

Additional Program Highlights

1. Through the Recovery Markers Questionnaire, adults self-reported similar assessments of their recovery status and outlook on life as did adults in other adult BHS programs.
2. At baseline, the Child and Adolescent Needs and Strengths assessment indicated multiple needs that BHConnect providers could address in their treatment plan with their child/youth.
3. BHConnect staff indicated the most common difficulties in providing telehealth services were poor/unstable internet connections, device malfunctions, and user error in accessing the telehealth services. Besides some of these issues, BHConnect staff did not indicate any major limitations to the provision of therapy via telehealth.
4. WHH was an important BH Connect service partner who facilitated ongoing engagement via the telehealth device to manage scheduling and provide wellness check-ins, primarily via video.

Conclusion

During FY 2019-20, the first full year of program operations, BHConnect demonstrated the viability of the initial program design (i.e., only having one in-person interaction before conducting everything else via telehealth). This model was ideal with the onset of the COVID-19 pandemic and the need for many different types of services to be provided remotely. BHConnect engaged in extensive outreach and educational activities to increase awareness of BHConnect services; however, generating substantial numbers of client referrals from other crisis-oriented mental health service provider organizations was an ongoing challenge. Additional approaches for increasing referrals will be pursued during FY 2020-21. Recognizing that a portion of these clients may only participate in services for a limited amount of time, BHConnect will develop short-term treatment priorities during FY 2020-21 in an effort to impart as many key educational and therapeutic benefits as possible to clients during the initial visits.

Primary Recommendations for FY 2020-21

1. Continue outreach efforts with community providers to increase referrals into BHConnect.
2. Coordinate with BHS to utilize BHS-generated reports to identify and engage additional potential BHConnect candidates.
3. Explore strategies to increase active engagement in telehealth treatment services.
4. Develop short-term treatment priorities to maximize educational and treatment benefits of initial visits.

Program Description

BHConnect is funded through the Innovations (INN) component of the Mental Health Services Act. BHConnect was developed to increase access and connection to follow-up behavioral health services after

a psychiatric emergency in which a San Diego resident utilized psychiatric hospital, emergency screening, and/or crisis response services. Services are provided through Vista Hill.

BHConnect services focus on persons who have received crisis-oriented psychiatric care services, but who are otherwise unconnected to behavioral health treatment services. The goal is to reduce recidivism rates for psychiatric crisis services among these persons by providing specialized supports through elemental treatment services that reduce barriers to accessing ongoing care. San Diego County residents of all ages are eligible for BHConnect services. Services are culturally and developmentally appropriate and aim to overcome current barriers when clients attempt to connect to care following a psychiatric crisis.

Offering services entirely through a telehealth platform, after an initial onsite evaluation by a case manager, is a key innovative component of the BHConnect program. To facilitate better access to care services, BHConnect provides clients with the technology necessary to maintain contact with telehealth professionals, such as tablet or phone equipped with built-in internet access. Clients receive a full tutorial of how to use the technology, as well as assistance with in-home set up prior to being connected with a behavioral health professional. As part of BHConnect, WHH services are available 24 hours a day/7 days a week to provide telehealth technical support, treatment scheduling reminders, follow-up for missed appointments, and to direct any crisis requests to appropriate services.

Welcome Home Health Activities

WHH is a key partner in the provision of BHConnect services. The primary role of WHH is to facilitate and manage initial and ongoing technological connections with BHConnect clients. Following agreement to participate in BHConnect services, a computer tablet or phone is provided to the client by BHConnect staff to use for their telehealth services (note: the functionality of the tablet is restricted to only allow access to WHH telehealth services so no other activities such as browsing the internet are possible). Once the device is provided to the client, a WHH representative will connect with the client via the device to introduce WHH and describe how to access telehealth services. WHH will also work with the BHConnect client to establish a plan for how best to participate in telehealth services (e.g., finding the best locations for good internet connectivity in the home, creating a plan for when any potential disruptions occur, etc.). A representative from WHH will also schedule the telehealth services, provide daily check-ins via the device until the first appointment, and then follow up with periodic check-ins and reminders throughout treatment. WHH services are available 24 hours a day/7 days a week to help with questions, provide check-ins, and to direct clients to crisis services if needed. In addition to the direct interactions with BHConnect clients, WHH and BHConnect staff regularly meet to review program operations and discuss specific cases. This communication and coordination ensures that staff from both partner organizations are aware of issues related to the well-being and ongoing treatment of BHConnect clients.

Table 1 provides an overview of the interactions between BHConnect clients and WHH for June 2020, the last month of FY 2019-20. While all WHH calls had the primary purpose of scheduling or confirming treatment appointments, approximately half (49.5%) had a wellness/treatment support component as well. A small but important subset of calls (3.4%) involved crisis/urgent issues that prompted referrals to the BHConnect treatment team. The majority of calls were conducted via video (83.6%). Reflecting the capability for two-way communication, 33.4% of the calls were initiated by BHConnect clients. For these calls, the average response time for WHH representative availability was less than three minutes. These findings highlight how multiple purposes can be accomplished through the communication between WHH

representatives and BHConnect clients to support engagement in telehealth treatment services. Additionally, the high percentage of video calls indicate that BHConnect clients typically had reliable internet connections, could successfully navigate the device, and were comfortable with the video interactions – all of which are important precursors for participating in video telehealth treatment services.

Table 1. WHH Calls with BHConnect Clients during June 2020 (N=293)

Type of Call	N	% of Total WHH Calls
Appointment scheduling/confirmation calls	293	100%
Wellness check-in/goal follow up calls	145	49.5%
Crisis/urgent calls referred to BHConnect team	10	3.4%
Additional Call Information		
Calls conducted via video	245	83.6%
Calls conducted via phone	48	16.4%
Calls initiated by BHConnect clients	98	33.4%
Average response time for calls initiated by client	2.9 min.	

Service Changes Due to COVID-19

The COVID-19 pandemic first substantially affected the San Diego area during March 2020. The County of San Diego issued a public health order effective 3/13/2020 to limit the size of public gatherings to less than 250 persons and to restrict access to hospitals and long-term care facilities serving seniors. This was followed by a statewide public health order on 3/19/2020 that required all non-essential workers to stay at home. During this time period county BHS programs had to quickly adapt to the new service delivery environment to protect both client and staff safety, while continuing to provide mental health services. For many programs, these changes included a switch to or greater utilization of telehealth services.

The initial design of BHConnect, which already relied exclusively on the provision of mental health treatment services via telehealth technologies, allowed BHConnect to adjust to the new practice realities with essentially no disruption to ongoing treatment services. The main changes for BHConnect due to the pandemic were staff and client safety-related practices such as social distancing, use of personal protective equipment, and implementing new cleaning protocols for the initial recruitment interactions and/or when providing the telehealth device to the client (which often now occurs at the client's home). A more detailed discussion of BHConnect experiences with providing telehealth services and the impact of COVID-19 on staff is included in other sections of the report.

Participant Characteristics

A brief overview of the BHConnect participant characteristics is presented here with a more complete listing in the report appendix. The BHConnect program provided mental health outpatient treatment services to clients of all ages through both the CYF and AOA BHS service systems. During FY 2019-20, a

total of 37 persons enrolled in CYF services and 17 enrolled in AOA services. CYF clients ranged in age from 5-18 with the majority (64.9%; n=24) between the ages of 15-18. AOA clients ranged in age from 18-65, with 35.3% (n=6) as Transitional Age Youth (TAY) between the ages of 18-25. Approximately two-thirds (64.9%; n=24) of the CYF clients were female, whereas the majority of AOA clients were male (58.8%; n=10). The majority of both CYF and AOA clients identified as Heterosexual or straight (78.4%; n=29 and 76.5%; n=13, respectively).

Utilization of Program Services

BHConnect Services – Type and Amount

Often, there was a brief period of time (typically 2-4 days), between enrolling into BHConnect (following an acute care treatment episode), and receiving initial BHConnect services. During this time the WHH team would attempt to maintain daily contact with the newly enrolled BHConnect clients until their first therapy session. Despite these WHH activities, a portion of BHConnect enrollees (16.2% of youth and 35.3% of adults) did not participate in any BHConnect services during FY 2019-20. BHConnect stakeholders and evaluators will continue to examine this group of enrollees in the future to identify any potential characteristics or needs this group has that may inform enhanced engagement strategies. Table 2 shows the overall service utilization patterns for persons who enrolled in BHConnect services during FY 2019-20. On average, youth and adults enrolled and receiving BHConnect services had approximately 10 total services (9.6 and 11.8, respectively) as of 6/30/2020. Of those that participated in at least one BHConnect therapy session, the mean number of therapy sessions received by youth and adults was 6.9 and 9.9, respectively. Out of all BHConnect enrollees, 64.9% of youth (n=24) and 41.2% of adults (n=7) received at least three therapy sessions from BHConnect clinicians.

Table 2. BHConnect Service Utilization

	Youth (N=37)			Adult (N=17)		
	Persons with at least one svc.		Mean number of services (of persons with svc.)	Persons with at least one svc.		Mean number of services (of persons with svc.)
Type of Service	n	%		n	%	
Any BHConnect service	31	83.8	9.6	11	64.7	11.8
Psychosocial assessment provided	27	73.0	1.4	9	52.9	1.2
Treatment plan session	23	62.1	1.0	8	47.0	1.0
Therapy sessions provided	29	78.4	6.9	10	58.8	9.9
Case management sessions provided	4	10.8	1.0	2	11.8	2.0
Other services provided (e.g., collateral contacts)	14	37.8	2.4	4	11.0	2.0
Received at least three therapy sessions	24	64.9	-	7	41.2	-

BHConnect Services – Duration and Discharge Status

As shown in Table 3, of the 37 youth and 17 adults who enrolled in BHConnect services during FY 2019-20, there were 19 youth and 7 adults active in the program as of 6/30/2020. These persons were typically enrolled for approximately three months (i.e., median duration of 91 days and 84 days, respectively), however there was a wide range for both youth and adults (i.e., duration of 7 to 220 days and 5 to 209 days, respectively). Of the persons who closed out of BHConnect prior to 6/30/2020, the duration times were generally much shorter (i.e., median durations of 44.5 and 37.0 days, respectively), which reflects the fact that a portion of the BHConnect enrollees were only in the program for a brief period of time. While the Year 1 sample sizes are too small to draw definitive conclusions, the program duration patterns suggest some initial "sorting out" of client preferences and interest levels during the initial few weeks of BHConnect involvement; some closed out of services within a month or less, but many others connected with and maintained treatment for 3 months or more. These duration patterns will continue to be monitored in future years to better understand factors that promote engagement with BHConnect services.

Table 3. BHConnect Program Participation Duration and Discharge

	Youth (N=37)		Adult (N=17)	
	Still in program	**Discharged**	**Still in program**	**Discharged**
N (persons)	19	18	7	10
Mean (days)	103.7	46.7	87.3	62.1
Median (days)	91.0	44.5	84.0	37.0
Std. Dev. (days)	62.5	31.8	74.2	69.7
Minimum (days)	7	8	5	3
Maximum (days)	220	119	209	231

Primary Program Outcomes

Child/Youth Baseline Assessments

Child and Adolescent Needs and Strengths

The Child and Adolescent Needs and Strengths (CANS) is a structured assessment used for identifying actionable needs and useful strengths among youth aged 6 to 21. It provides a framework for developing and communicating a shared vision by using information from both the youth and family members to inform planning, support decisions, and monitor outcomes. The CANS is completed by providers at initial assessment, 6-month reassessment, and discharge.

The CANS assessment includes a variety of domains to identify the strengths and needs of youth. Each domain contains a certain number of questions that are rated 0-3, with a "2" or "3" indicating a specific domain that should be addressed in the service or treatment plan. Within a domain, the number of

questions rated at least a 2 or a 3 can be counted as a way to see which areas indicate a higher need for support. Table 4 shows the mean counts of the initial assessment needs for the domains of Child Behavioral/Emotional Needs, Life Functioning, and Risk Behaviors.

Of the 28 CANS assessments completed during the initial intake, on average, providers recorded approximately two needs in both the domains of Child Behavioral/Emotional Needs and Life Functioning and one need in the domain of Risk Behavior. These CANS ratings indicate that there are multiple needs for BHConnect providers to try to address in partnership with BHConnect clients. In future reporting periods, it is anticipated that there will be a sufficient sample size to assess for improvements between initial and follow-up/discharge CANS ratings.

Table 4. Child and Adolescent Needs and Strengths (CANS) at Baseline (N=28)

CANS Domain	Initial mean number of needs
Child behavioral/emotional needs	2.1
Life functioning	1.7
Risk behaviors	0.9

Pediatric Symptoms Checklist

The Pediatric Symptoms Checklist (PSC-35) is a screening tool designed to support the identification of emotional and behavioral problems. Caregivers complete the PSC-Parent version on behalf of children and youth ages 3 to 18, and youth ages 11 to 18 complete the self-report PSC-Youth version. Clinical cutoff values[1] indicating impairment for emotional and behavioral problems are seen through the total PSC score and through the three subscales contained within the PSC located below in Table 5. In FY 2019-20, the PSC-35 was administered at entry into BHConnect, at 6-month reassessment, and discharge. Table 5 shows about half of all youth were above the total PSC clinical cutoff score as reported by caregivers (50.0%) and youth (57.7%) at baseline. Mean scores across the total score and three subscales were generally consistent between caregivers and youth. The Internalizing subscale domain was most commonly rated above the clinical cut point (i.e., 66.7% of caregiver reports and 73.1% of youth self-reports).

[1] *PSC Cutoff Scores: Total PSC Score ≥ 28, Attention Subscale ≥ 7, Internalizing Subscale ≥ 5, Externalizing Subscale ≥ 7*

Table 5. Pediatric Symptoms Checklist (PSC) at Baseline

	Caregiver Report			Youth Report		
Higher scores indicate worse condition	N	% Above cutoff	Mean	N	% Above cutoff	Mean
PSC Total Score	24	50.0%	28.1	26	57.7%	29.1
Attention Subscale	24	25.0%	4.6	26	30.8%	5.6
Internalizing Subscale	24	66.7%	5.5	26	73.1%	6.0
Externalizing Subscale	24	12.5%	3.2	26	15.4%	3.2

Adult Baseline Assessments

Recovery Markers Questionnaire

The Recovery Markers Questionnaire (RMQ) is a 26-item questionnaire that assesses elements of recovery from the client's perspective. It was developed to provide the mental health field with a multifaceted measure that collects information on personal recovery. The results listed below have been rescaled to the following: 1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; and 5 = Strongly Agree, with higher values corresponding to higher levels of well-being. The RMQ asks persons to answer questions as it is "true for you now." The total mean RMQ score for the 8 adult participants who completed it at intake was 3.6. As reported in the Mental Health Outcomes Management System (mHOMS) Annual Outcomes Report for FY 2018-19 (the most recent version available for comparison), the average RMQ at intake for other BHS treatment programs (e.g., outpatient, ACT, case management, and TAY residential programs) was 3.4. It appears that BHConnect participants self-report similar assessments of their recovery status and outlook on life as do clients in other BHS programs.

Illness Management and Recovery

To measure clinician perception of client recovery, the Illness Management and Recovery (IMR) scale was completed by BHConnect staff. The IMR scale has 15 items, each addressing a different aspect of illness management and recovery. Each item can function as a domain of improvement. Additionally, there are three subscales known as Recovery, Management, and Substance Abuse. IMR scores range from 1 to 5, with 5 representing the highest level of recovery. The mean overall IMR score (n=9) at intake was 2.5. As reported in the mHOMS Annual Outcomes Report for FY 2018-19 (the most recent version available for comparison), the average overall IMR intake score for other outpatient programs was 2.8. With the small sample size no definitive conclusions are possible, however, it appears that clinicians assessed BHConnect participants to have fairly similar levels of impairment as seen among participants in other BHS programs. Of note, BHConnect participants reported fairly high levels of involvement of others in their mental health treatment, using medications effectively, and limited impairment due to substance use (i.e., all were rated 3.6 or higher on a 5-point scale); however, mental health management was rated low (i.e., 1.6 on a 5-

point scale). These findings and potential changes in IMR scores will be evaluated in future reporting periods as the sample sizes increase.

Table 6. IMR Assessments for BHConnect Adult Clients (N=9)

	Baseline	
IMR Assessment Item/Subscale	**N**	**Mean**
Involvement of family and friends in his/her mental health treatment: How much are family members, friends, boyfriends or girlfriends, and other people who are important to him/her (outside the mental health agency) involved in his or her health treatment?	9	3.9
Time in structured roles: How much time does s/he spend working, volunteering, being a student, being a parent, taking care of someone else or someone else's house or apartment?	9	1.8
Psychiatric hospitalizations: When is the last time s/he has been hospitalized for mental health or substance abuse reasons?	9	1.1
Using medication effectively: How often does s/he take his/her medication as prescribed?	9	3.6
Recovery subscale	9	2.6
Management subscale	9	1.6
Substance abuse subscale	9	3.8
Overall IMR	**9**	**2.5**

Additional Program Activities

Establishing Referral Sources

Per the initial design of the BHConnect program, potential clients are identified at crisis-oriented mental health service programs such as the Emergency Stabilization Unit (ESU), Child and Adolescent Psychiatry Services (CAPS), and the San Diego County Psychiatric Hospital (SDPH). Establishing a network of referral sites throughout FY 2019-20 required extensive BHConnect outreach efforts that involved meeting with representatives of potential partner organizations to educate them about BHConnect services and develop processes for identifying and screening potential clients. Additionally, BHConnect gave presentations at multiple community service provider meetings to increase awareness of BHConnect services. Overall, fewer referrals than expected were generated from potential partners, which prompted ongoing outreach and networking activities for much of FY 2019-20. To help facilitate referrals with some partners (e.g., ESU), BHConnect staff were stationed on location to assist with identifying and screening potential candidates. For locations without an onsite BHConnect presence, a referral process was designed and revised to allow for a brief screening call to determine eligibility of potential candidates interested in BHConnect services.

Primary Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings and 2) the Annual BHConnect Staff Survey. The stakeholder meetings were held throughout the year with representatives from BHS, BHConnect, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual BHConnect Staff Survey was conducted at the end of FY 2019-20. BHConnect program staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. All BHConnect staff invited to participate in the survey did so, for a 100% response rate (n=7). For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses and any discrepancies were discussed to arrive at a consensus on the key response themes.

Challenges Establishing Referral Network

As discussed above, BHConnect engaged in extensive outreach and education activities throughout FY 2019-20 in an effort to establish referral partnerships with crisis-oriented mental health service providers. Organizations typically expressed interest in having BHConnect as a new outpatient resource to offer clients following crisis episodes; however, the number of resulting referrals was substantially less than anticipated. While the specific reasons for this likely varied between organizations, the main barrier appeared to be difficulties with introducing change into well-established referral processes. In response, the BHConnect team streamlined the screening and referral process to reduce potential burdens or complexities that might inhibit identification of BHConnect candidates. Referrals increased near the end of FY 2019-20, which was due to both the ongoing efforts of the BHConnect team as well as the increased interest in telehealth-based mental health services brought on by the COVID-19 pandemic.

Recruitment of Potential BHConnect Participants

The BHConnect staff reported that successful client recruitment was facilitated by key program components such as offering clients a dedicated device for the telehealth services, providing crisis coverage for telehealth services 24 hours a day/7 days a week via the WHH partnership, and enabling clients to quickly start services (i.e., not get put on a program waitlist).

Engagement and Retention of BHConnect Participants

As a program designed to work with clients who have experienced a mental health related crisis, but were otherwise unconnected to outpatient services, ambivalence or resistance to treatment among some clients was anticipated. Consistent with expectations, BHConnect staff survey responses identified client engagement with treatment services and client attrition as substantial challenges during FY2019-20. In this regard, the capabilities of BHConnect to reduce treatment burdens via easy to access telehealth services and 24/7 availability were viewed by staff as instrumental to program success, but still subject to client motivation and interest to participate in services. In this regard, the telehealth approach of BHConnect may represent a necessary, but not entirely sufficient, condition to keep some persons in treatment. Further explorations into strategies to promote client engagement in telehealth services will be conducted during FY 2020-21.

Experiences with Telehealth Services

When BHConnect staff were asked about the most common difficulties they encountered when providing telehealth the primary answers were technology involved: internet connectivity issues (in both rural and urban settings), experiencing problems/challenges with devices, troubleshooting user error in accessing the telehealth services, etc. Staff indicated that between 11-25% of telehealth calls experienced some type of disruption due to connectivity or device issues. Staff indicated that most participants were comfortable with the video aspect of the telehealth sessions and there were few requests for telephone only telehealth sessions. When asked to compare their BHConnect telehealth experiences to prior in-person therapy experiences, staff indicated that the approaches were fairly equivalent in key therapeutic domains of establishing relationships with clients, having quality communication, and engaging clients in services. Overall, besides some issues with devices and maintaining internet connectivity, BHConnect staff did not indicate any major limitations to the provision of therapy via telehealth.

Impact of COVID-19 on BHConnect Staff

Overall, BHConnect staff members indicated there were aspects of their lives, both related and unrelated to work, which changed substantially due to the COVID-19 pandemic and contributed to some elevated levels of personal stress and anxiety.

Program Recommendations

1. Continue outreach efforts with community providers to increase referrals into BHConnect.
2. Coordinate with BHS to utilize BHS-generated reports to identify and engage additional potential BHConnect candidates.
3. Explore strategies to increase active engagement in telehealth treatment services.
4. Develop short-term treatment priorities to maximize educational and treatment benefits of initial visits.

Conclusion

During FY 2019-20, the first full year of program operations, BHConnect enrolled 54 persons (37 youth and 17 adults). BHConnect engaged in extensive outreach and educational activities to increase awareness of BHConnect services throughout FY 2019-20; however, a primary challenge for BHConnect was the difficulty generating substantial numbers of client referrals from other crisis-oriented mental health service provider organizations. While referrals increased during the final months of FY 2019-20, continued efforts to prompt more referrals into BHConnect are expected during FY 2020-21.

Apart from the low number of referrals, the basic initial design of the program (i.e., only having one in-person interaction before conducting everything else via telehealth), proved viable and actually fortuitous with the onset of COVID-19 pandemic and the need for many different types of services to be provided remotely. The WHH partner was successfully able to support program operations via maintaining communication with BHConnect clients between treatment sessions. While the telehealth services made participation in treatment services more convenient, the focal client population (i.e., those unconnected to treatment), still exhibited some difficulties with treatment engagement and retention in services. An

assessment of program duration indicated that of those who had discharged from BHConnect services, 50% of both CYF and AOA clients did so within approximately the first 45 days. Examining strategies to enhance telehealth treatment engagement and retention in services will be an objective for FY 2020-21. Additionally, recognizing that a portion of these clients may only participate in services for a limited amount of time, BHConnect will develop short-term treatment priorities during FY 2020-21 in an effort to impart as many key educational and therapeutic benefits as possible to clients during the initial visits.

For more information about this Innovation program and/or the report please contact:
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Appendix

Characteristics of Participants who Enrolled during FY 2019-20

Characteristic	Child/Youth (N=37)		Adult (N=17)	
Gender	N	%	N	%
Male	13	35.1%	10	58.8%
Female	24	64.9%	7	41.2%
Total	37	100%	17	100%
Primary Language	N	%	N	%
English	36	97.3%	16	94.1%
Other	1	2.7%	1	5.9%
Total	37	100%	17	100%
Race/Ethnicity	N	%	N	%
Hispanic/Latino	22	59.5%	-	-
Caucasian/White	11	29.7%	7	41.2%
Multi-racial/Other/Missing	8	21.6%	10	58.8%
Total[1]	-	-	-	-
Sexual Orientation	N	%	N	%
Heterosexual or straight	29	78.4%	13	76.5%
Another sexual orientation/Prefer Not to Answer/Missing	8	21.6%	4	23.5%
Total	37	100%	17	100%

Characteristic	Child/Youth (N=37)		Characteristic	Adult (N=17)	
Age Group	N	%	Age Group	N	%
5 to 14	13	35.1%	18 to 25	6	35.3%
15 to 18	24	64.9%	26 to 65	11	64.7%
Total	37	100%	Total	17	100%

[1] *Total may exceed 100% since more than one race/ethnicity could be selected.*



ROAMING OUTPATIENT ACCESS MOBILE (ROAM) INNOVATIONS-20

Annual Report
Year 2 (7/1/2019 - 6/30/2020)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES (v.12.28.2020)

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO | UC San Diego

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Executive Summary

Program Overview

The Roaming Outpatient Access Mobile (ROAM) program was designed to increase access to and utilization of culturally competent mental health services in rural American Indian populations to decrease the effects of untreated mental health and co-occurring conditions. Two organizations, the Indian Health Council (IHC) and Southern Indian Health Council (SIHC) were selected to provide ROAM services. To facilitate access to care and to help treat the typically underserved American Indian population, the ROAM program adopted the use of mobile health clinics to provide effective health services in areas that may be typically hard to reach as well as offering telehealth and telepsychiatry services to lessen the need for in-person, in-clinic visits. For both the IHC and SIHC ROAM programs, the onset of the COVID-19 pandemic and the required safety precautions led to the suspension of all in-person service provision, except for crisis situations. This also prevented the use of the mobile health units at each program.

Primary Findings for Fiscal Year (FY) 2019-20

1. During FY 2019-20, 242 participants enrolled into one of the ROAM programs (93 into IHC and 149 into SIHC).
2. The ROAM program provided nearly 1,900 behavioral health related services across both IHC and SIHC including services such as cognitive behavioral therapy, trauma informed therapy, substance abuse counseling, and medication management.
3. Depression assessments among the population enrolling into the ROAM programs demonstrated that across both programs many of the ROAM participants were showing signs of mild to moderate depression.
4. The Milestones of Recovery Scale (MORS) indicated that on a recovery scale of 1-8, with higher scores indicating greater recovery, on average, persons were enrolling into both IHC and SIHC with a score of approximately 5.0, which corresponds with a recovery level of “not coping, engaged.”
5. Due to COVID-19, the ROAM programs accelerated the planned adoption of telehealth and telepsychiatry services via phone and video sessions. While there were some difficulties with connectivity, overall both the IHC and SIHC ROAM teams reported generally favorable experiences using technology to engage with persons and provide behavioral health services. With the transition

to telehealth services, ROAM program staff reported seeing a decrease in "no-shows" for scheduled appointments and an increase in client willingness to participate in program services.

6. The COVID-19 related disruptions to the planned use of the mobile health units coupled with delays due to repairs during the early part of the year resulted in limited utilization of the mobile health units during FY 2019-20.

Conclusion

Overall, FY 2019-20 was a challenging, but ultimately successful year in terms of both the IHC and SIHC ROAM programs implementing all of their relevant service approaches (even with the limited time using the mobile health units), developing outreach activities, and fully incorporating telehealth and telepsychiatry services into their operations. The lessons learned from the experiences during FY 2019-20 will help inform continued refinement of ROAM practices in FY 2020-21 and contribute to anticipated growth in the number of persons able to benefit from ROAM services.

Primary Recommendations for FY 2020-21

1. Refine plans for strategic utilization of mobile health units (once safe to redeploy) and integration with telehealth services.
2. Address technological barriers related to conducting telehealth services (e.g., issues with internet connectivity, availability of suitable devices).
3. Enhance evaluation approaches to identify primary impacts of ROAM services on participants.

Program Description

The County of San Diego Health and Human Services Agency's (HHSA) Behavioral Health Services (BHS) ROAM program is funded through the Innovations (INN) component of the Mental Health Services Act. ROAM was developed to provide fully mobile mental health clinics to American Indians of all ages in the North Inland and East County regions of San Diego. The ROAM teams at both IHC and SIHC included licensed therapists and psychiatrists, and the IHC ROAM team also included a licensed substance use disorder (SUD) counselor. In order for the programs to provide culturally competent services that are sensitive to the needs of American Indians, the majority of ROAM staff at both IHC and SIHC identified as American Indians.

Efforts by ROAM are intended to improve access to and utilization of mental health services for American Indian children, transitional age youth (TAY), adults, and older adults residing on tribal reservations and rural communities in San Diego County. A key eligibility criterion for ROAM services is whether barriers are identified that would inhibit participation in standard clinic-based outpatient behavioral health care services. ROAM services aim to decrease behavioral health symptoms and improve level of functioning for participants, while also improving care coordination and access to physical health care. Each ROAM team is staffed with culturally competent licensed and unlicensed professionals who can provide a variety of care services. In addition, the ROAM program will use telehealth for on-going and continuing mental health needs to decrease burdens for accessing needed services. The usage of telehealth in conjunction with, rather than in lieu of, face-to-face services was expected to be a key factor in minimizing barriers to

treatment and furthering mental health engagement. To facilitate better access to care services, the program will provide at least some services at night and/or on the weekends to better match availability of participants.

Service Changes Due to COVID-19

The COVID-19 pandemic first affected the San Diego area in a substantial manner during March 2020. The County of San Diego issued a public health order effective 3/13/2020 to limit the size of public gatherings to less than 250 persons and to restrict access to hospitals and long-term care facilities serving seniors. This was followed by a statewide public health order on 3/19/2020 that required all non-essential workers to stay at home. During this time period County BHS programs had to quickly adapt to the new service delivery environment to protect both client and provider safety while continuing to provide mental health services. For many programs, these changes included a switch to or greater utilization of telehealth services.

For the IHC and SIHC ROAM programs, the onset of the COVID-19 pandemic and the required safety precautions led to the suspension of all in-person service provision, except for crisis situations. This also prevented the use of the mobile health units at each program. Prior to the COVID-19 pandemic, both programs had started to explore the use of telehealth services to support their in-clinic and mobile health unit ROAM activities, but telehealth services, particularly using video technology, were not commonly utilized. After the emergence of COVID-19, both programs quickly established the capability to provide telehealth services via a mixture of telephone and video-supported interactions with clients. In this regard, there were limited disruptions to the delivery of services to current ROAM participants. A more detailed discussion of the experience with telehealth services is provided below. Where relevant, findings and recommendations in this report indicate aspects potentially related to the unique challenges that COVID-19 posed within the local community and health care environment throughout the end of FY 2019-20.

Participant Characteristics

A brief overview of the ROAM participant characteristics is presented here with a more complete listing found in the report appendix. In general, the characteristics of the enrollees in the respective ROAM programs were similar. Of the 242 participants enrolled in ROAM during FY 2019-20 (93 from IHC and 149 from SIHC), the majority (54.1%) identified as female, spoke English (99.2%) and indicated their race/ethnicity to be American Indian (88.0%). Asked if they had a disability that was not the result of a serious mental illness (SMI), 31.4% indicated having a disability and 15.7% indicated their disability was a chronic health condition. One area in which the two programs differed to some extent was in the age distribution of their ROAM participants. As shown in Table 1, close to half of SIHC participants were age 25 or younger (41.6%) as compared to less than 16.1% of those receiving ROAM services at IHC (exact numbers less than 5 are obscured). At the other end of the age continuum, almost 20% (18.3%) of IHC participants were over the age of 65, whereas this age group comprised only 8.7% of SIHC participants.

Table 1. Age Distribution of ROAM Participants by Program

	IHC		SIHC	
Age	**N**	**%**	**N**	**%**
<16	<5	<5.4%	29	19.5%
16-25	10	10.7%	33	22.1%
26-45	38	40.9%	45	30.2%
46-65	25	26.9%	25	16.8%
>65	17	18.3%	13	8.7%
Missing/Prefer not to answer	-	-	4	2.7%
Total	**93**	**100**	**149**	**100**

Utilization of Program Services

ROAM Behavioral Health Service Provision

The 93 persons enrolled in IHC ROAM received a total of 1,121 services (average of 12.1 services per person) and the 149 persons enrolled in SIHC ROAM received a total of 753 services (average of 5.1 services per person). As shown in Table 2, a key area of difference between the two programs was the provision of substance abuse counseling, with over half (52.7%) of IHC participants receiving at least one such service compared to less than 3.3% of SIHC participants (exact numbers less than 5 are obscured). This difference reflects the composition of the respective ROAM teams at IHC and SIHC and the inclusion of an SUD counselor at IHC.

Similar percentages of participants from IHC and SIHC received cognitive behavioral therapy (32.3% and 31.5%, respectively), however trauma informed therapy was more prevalent at SIHC (38.9% and 19.4%, respectively). For both programs, medication management was a relatively common service provided to ROAM participants, with 26.9% and 34.9%, respectively having at least one medication management session. While there were some differences between the IHC and SIHC programs, most notably the emphasis on substance abuse counseling evident at IHC, the overall findings highlight the wide range of service activities that were provided to persons who may have had difficulty accessing needed behavioral health care through traditional outpatient clinic settings.

Table 2. Number and Type of ROAM Service Contact by Program

	IHC				SIHC			
	Total persons (n=93)		Total services (n=1,121)		Total persons (n=149)		Total services (n=753)	
	Number of persons with service	Percent of persons with service	Number of services	Percent of total services	Number of Persons with service	Percent of persons with service	Number of services	Percent of total services
Assessment	62	66.7%	82	7.3%	89	59.7%	122	16.2%
Psychoeducation: Individual	36	38.7%	197	17.6%	<5	<3.3%	7	0.9%
Psychoeducation: Group	<5	<5.4%	<5	<0.5%	29	19.5%	29	3.9%
Therapy-Cognitive Behavioral: Individual	30	32.3%	232	20.7%	47	31.5%	296	39.3%
Therapy-Cognitive Behavioral: Group	20	21.5%	85	7.6%	<5	<3.3%	<5	<0.7%
Therapy-Trauma Informed: Individual	18	19.4%	119	10.6%	58	38.9%	162	21.5%
Therapy-Family Involved	<5	<5.4%	<5	<0.5%	21	14.1%	44	5.8%
Substance Abuse Counseling	49	52.7%	463	41.3%	<5	<3.3%	<5	<0.7%
Referral to Substance Abuse Counseling	<5	<5.4%	<5	<0.5%	11	7.4%	13	1.7%
Case Management	<5	<5.4%	12	1.1%	22	14.8%	51	6.8%
Medication Management	25	26.9%	123	11.0%	52	34.9%	203	27.0%
Traditional Healing-BH related	<5	5.4%	22	2.0%	0	0.0%	0	0.0%

Primary Program Outcomes

Patient Health Questionnaire

The Patient Health Questionnaire (PHQ) is a well validated, brief tool for identifying depression. The two-item PHQ-2 is often used as a depression screener while the PHQ-9 is used for a more complete assessment of depression symptoms. A total of 44 persons at IHC and 62 persons at SIHC completed a PHQ-9 at the time of enrollment into ROAM. The average and median PHQ-9 scores were similar for both

programs and indicative of mild/moderate depression for many ROAM participants. However, as shown in Table 3, the top 25% of the PHQ-9 scores were significantly more affected by depression symptoms with IHC showing scores of 14.3 and above, and SIHC showing scores of 13.8 and above, both of which correspond to moderate/moderately severe depression. Some ROAM participants only completed the PHQ-2 screener (not included in Table 3) and did not exhibit evidence of depression. Overall, this pattern of findings suggests substantial variability in the extent to which ROAM participants experienced depression when entering the ROAM program. In future reporting periods, changes in PHQ scores will be assessed as the number of participants with completed baseline and follow-up PHQ-9's increases.

Table 3. Intake PHQ-9 Scores by Program

	IHC	SIHC
Persons with completed baseline PHQ-9	**n=44**	**n=62**
Average PHQ-9 score	9.8	9.9
Standard Deviation	7.1	6.6
Median PHQ-9 score	9.0	8.5
Highest 25% PHQ-9 score	14.3	13.8

Milestones of Recovery Scale

The Milestones of Recovery Scale (MORS) captures recovery as assessed by staff using a single-item recovery indicator. Participants were placed into one of eight stages of recovery based on their level of risk, level of engagement within the mental health system, and the quality of their social support network. Raters are instructed to select the level describing the modal milestone of recovery that an individual displayed over the previous month. Higher MORS ratings indicate greater recovery. For those with a completed MORS score upon entry into ROAM, the average score was approximately 5.0 for both IHC and SIHC (which corresponds with "not coping, engaged"). There was some difference in the distribution of MORS scores with SIHC serving a higher percentage of persons with a MORS score between 1-4 than IHC, (35.6% and 14.0% respectively). Since MORS scores were not available for the full cohort of ROAM participants, there is uncertainty regarding the extent to which the ROAM population served by SIHC may have a higher proportion of more seriously impaired persons. This will continue to be monitored in future reporting periods as well as an assessment of potential changes in MORS score when more participants have completed both an intake and follow-up MORS.

Table 4. Intake MORS Scores by Program

		IHC (n=50)		SIHC (n=45)	
MORS Value	**MORS Categories**	**N**	**%**	**N**	**%**
1-4	*Extreme risk; High risk, not engaged; High risk, engaged; Not coping, not engaged*	7	14.0%	16	35.6%
5	*Not coping, engaged*	28	56.0%	13	28.8%
6-8	*Coping/rehabilitating; Early recovery; Advanced recovery*	15	30.0%	16	35.6%
	Mean MORS score	**5.2**		**4.8**	

Additional Program Activities

One of the primary objectives of the ROAM program was to link Tribal communities with resources to help improve mental and physical well-being. To improve linkages and increase utilization of treatment/services, a variety of outreach efforts were made to engage with the community and raise awareness of the ROAM program. Outreach efforts from both programs included attending services fairs, passing out flyers, allowing community members to walk through the mobile units, attending tribal gatherings (e.g., Pow Wows, health fairs), posting on social media about ROAM events/activities, conducting psychoeducation talks at community events, and hosting breakfasts.

Primary Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings and 2) the Annual ROAM Staff Survey. The stakeholder meetings were held throughout the year with representatives from BHS, ROAM, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual ROAM Staff Survey was conducted at the end of FY 2019-20. IHC and SIHC ROAM program staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. There were 10 respondents from the 15 IHC and SIHC ROAM staff invited to participate in the survey (a response rate of 66.6%). For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses, and any discrepancies were discussed to arrive at a consensus on the key response themes. Information included in the following sections is applicable to both the IHC and SIHC programs unless otherwise indicated.

Outreach and Recruitment of ROAM Participants

Expanding services to rural areas, improving access to care, and reaching underserved populations were among the primary goals ROAM staff identified in the Annual Survey. Staff indicated that positive coordination and communication with community partners led to successful outreach and recruitment, and more potential ROAM clients could be recruited through the use of community/cultural events.

Engagement and Retention of ROAM Participants

The ROAM program was designed to work with underserved populations in rural areas, and the ROAM staff reported that the best way of accomplishing that was through connecting with clients by listening, learning, and building strong relationships. Additionally, staff found providing consistent but flexible transportation options enhanced their ability to engage clients.

Both programs agreed that client engagement and retention would be strengthened by staff trainings in specific mental health topics such as Motivational Interviewing, Family/Group Therapy, and Eating Disorders. Specifically, the IHC program noted that additional trainings such as computer training, mobile unit function training, and driver training would help to better accomplish program goals.

Mobile Health Unit Experiences and Perspectives

For both IHC and SIHC, the mobile health units were only utilized for a brief period of time during FY 2019-20. Mechanical issues, repairs, and availability of trained drivers disrupted consistent use during the first part of the year and then the onset of the COVID-19 pandemic during March 2020 suspended use for the remainder of FY 2019-20. However, there was a period of time for each program when the mobile health units were operational and utilized to extend the reach of in-person services to more remote areas (i.e., approximately 10% of all FY 2019-20 service contacts for each ROAM program involved the mobile health units). During this time, the programs established fixed schedules for the units such that the behavioral health team would be available to provide in-person sessions at known locations throughout the more remote regions served by IHC and SIHC. Based on the experiences using the mobile health units to expand access to care and the unusual circumstances brought about by COVID-19, the IHC and SIHC teams indicated developing plans for re-introducing the mobile health units into their service delivery approach during FY 2020-21 after it becomes safe to do so. While there was general interest in and demand for these in-person mobile health unit services, ongoing outreach and engagement activities were recommended to increase community awareness and promote greater utilization of services by persons who might need them.

Experiences with Telehealth Services

When the ROAM staff were asked about the most common difficulties they encountered while providing telehealth services, the primary answer was technological issues such as frozen screens, ineffectual audio, software problems, and connectivity issues. In response to difficulties with internet connections, ROAM programs have been working with community partners to establish additional local Wi-Fi hotspot networks that persons can use when wanting to engage in telehealth services.

Staff also reported that approximately 20% of clients preferred to use the telephone and not telehealth with video. As compared to January-March 2020, the program reported an increase in client willingness to participate in services and over a 50% decrease in “no-shows” for appointments during April-June 2020. Other dimensions of client services, such as quality of communication, relationships, client focus, openness, and engagement in services, were perceived as not having been negatively impacted by providing telehealth services as compared to in-person services. Overall, the general response regarding the switch to primarily offering services via telehealth has been largely positive, potentially even more positive than program staff were anticipating.

Impact of COVID-19 on ROAM Staff

Administered during the summer of 2020, the staff survey had the opportunity to collect information on the COVID-19 pandemic and its impact on staff. Overall, staff members indicated there were aspects of their lives, both related to work and unrelated to work, that changed due to the COVID-19 pandemic.

Staff noted that the pandemic had, to a great extent, created additional stress and anxiety in their lives. To help manage or reduce stress and anxiety related to the pandemic, staff reporting using coping skills such as self-care (e.g., exercise, therapy, sleep, etc.), hobbies (e.g., games, spending time outside), and connecting with coworkers and other personal relationships. Overall, staff noted that the change in workspace and not being able to work from the office impacted their abilities to interact with clients. Specifically, SIHC reported that COVID-19 had a notable impact on client retention.

Program Changes from Initial Design

Besides the changes in service provision due to the COVID-19 pandemic (i.e., suspending use of the mobile unit and in-person counseling), there were not any major changes from the initial design and goals of the ROAM program.

Program Recommendations

1. Refine plans for strategic utilization of mobile health units (once safe to redeploy) and integration with telehealth services.
2. Address technological barriers related to conducting telehealth services (e.g., issues with internet connectivity, availability of suitable devices).
3. Enhance evaluation approaches to identify primary impacts of ROAM services on participants.

Conclusion

Between both the IHC and SIHC ROAM programs almost 1,900 behavioral health related services were provided to 242 persons during FY 2019-20. These persons were eligible to receive ROAM services because they had barriers that inhibited them from participating in standard clinic-based outpatient behavioral health treatment. In this manner, ROAM provided essential behavioral health services to persons, primarily American Indians, who would likely not have received needed care. The baseline PHQ-9 and MORS scores indicated that many in the overall ROAM service population experienced mild/moderate depression and/or were not coping well with their mental health symptoms, but were interested in engaging in treatment services. However, fluctuations in symptom management over time and variability in the severity of mental health needs within the population resulted in the ROAM care teams also responding to and treating serious mental health situations throughout FY 2019-20.

ROAM was designed to provide expanded access to care through two primary mechanisms: 1) a mobile health unit that would bring behavioral health care teams to remote areas of San Diego County with limited availability of behavioral health care services, and 2) expanded use of telehealth and telepsychiatry to connect behavioral health professionals with persons who need services via telephone and video sessions. Unfortunately, various delays prevented the use of the mobile health units at both IHC and SIHC at various times during FY 2019-20 and then the onset of the COVID-19 required suspending use of the

mobile health units as of March 2020. During the limited amount of time that the mobile units were operational, both clinics established traveling location schedules and refined techniques for the outreach and communication needed to raise community awareness of available services. The programs are continuing to plan for how best to utilize the mobile health units once such operations are determined to be safe and feasible in FY 2020-21.

The second mechanism for increasing access to behavioral health care, expanded use of telehealth and telepsychiatry services, was more fully adopted following the emergence of COVID-19. In this manner, the external circumstances caused by the pandemic and the suspension of in-person visits required the ROAM staff and the entire IHC and SIHC organizations to quickly extend the offering of telehealth and telepsychiatry services. Based on feedback from both IHC and SIHC ROAM teams, the switch to greater utilization of telehealth approaches for providing behavioral health services was broadly embraced and viewed more favorably than originally anticipated. There were some challenges with internet connectivity for certain participants, but both programs indicated working to improve their capabilities to provide telehealth service and will continue to do so during FY 2020-21.

Overall, FY 2019-20, was a challenging, but ultimately successful year in terms of both the IHC and SIHC ROAM programs implementing all of their relevant service approaches (even if for a limited time with the mobile health units), developing outreach activities, and fully incorporating telehealth and telepsychiatry services into their operations. The lessons learned from the experiences during FY 2019-20 will help inform continued refinement of ROAM practices in FY 2020-21 and contribute to anticipated growth in the number of persons able to benefit from ROAM services.

For more information about this Innovation program and/or the report please contact:
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Appendix

Characteristics of Participants who Enrolled during FY 2019-20

Characteristic	Total Participants (N=242)	
Gender	N	%
Male	107	44.2%
Female	131	54.1%
Missing/Prefer not to answer	4	1.7%
Total	242	100%
Age Group	N	%
<16	32	13.2%
16-25	43	17.8%
26-45	83	34.3%
46-65	50	20.7%
>65	30	12.4%
Missing/Prefer not to answer	4	1.6%
Total	242	100%
Primary Language	N	%
English	240	99.2%
Missing/Prefer not to answer	2	0.8%
Total	242	100%
Race/Ethnicity	N	%
American Indian	213	88.0%
Latino	11	4.5%
Caucasian/white	19	7.9%
Multi-racial	8	3.3%
Other/Missing/Prefer not to answer	7	2.9%
Total[1]	-	-
Sexual Orientation	N	%
Heterosexual or straight	154	63.6%
Gay/Lesbian/Bisexual/Pansexual	6	2.5%
Missing/Prefer not to answer	82	33.9%
Total	242	100%
Military Status	N	%
Never served in the military	200	82.6%
General service	5	2.1%
Served in another country's military	12	5.0%
Missing/Prefer not to answer	25	10.3%
Total	242	100%

Characteristic	Total Participants (N=242)	
Disability	**N**	**%**
Yes, Has a disability	76	31.4%
No, Does not have a disability	123	50.8%
Declined/Preferred not to answer	43	17.8%
Total	242	100%
Type of Disability	**N**	**%**
Learning/Developmental/Other Mental	11	4.5%
Physical	11	4.5%
Chronic Health	38	15.7%
Other	24	9.9%
Total[2]	-	-

[1] *Total may exceed 100% since more than one race/ethnicity could be selected.*
[2] *Since participants could select more than one specific non-mental health related disability, the percentages may total more than the percent who indicated having any disability.*



JUST BE U INNOVATIONS-21

Annual Report
Year 2 (7/01/2019-6/30/2020)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES (v.12.28.2020)

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO | UC San Diego

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Executive Summary

Program Overview

The Just Be U (JBU) program was designed to improve the mental health and quality of life outcomes of Transitional Age Youth (TAY; age 18-25; referred to as "youth" throughout this report) with Serious Mental Illness (SMI) who are homeless or otherwise at risk of homelessness and repeatedly utilize acute or emergency mental health services, but are otherwise unconnected to services. JBU provides short-term housing for youth in a supportive environment that provides whole-health services targeting healthy eating, exercise, sleep, and a range of holistic interventions. Throughout these interactions with youth, JBU identifies and facilitates connections to individualized treatment, housing, and other community resources. Primary innovative features of JBU include the emphasis on youth-centric whole-health/holistic services and the utilization of technology as an important tool for communicating with and engaging youth.

As a residential program serving a population at high risk for exposure to disease (i.e., homeless youth), JBU staff maintained in-person operations throughout the COVID-19 pandemic by implementing CDC and San Diego County public health guidelines. While JBU's residential component continued without interruption, JBU suspended all in-person holistic services except those that could be socially distanced or completed via remote technologies and also stopped all community-based educational and enrichment events.

Primary Findings for Fiscal Year (FY) 2019-20

1. During FY 2019-20, JBU staff were able to successfully locate and contact 49.2% (n=123) of the 250 potentially eligible youth and enrolled 100% (n=42) of the youth determined to still be eligible for JBU services (i.e., not housed).

2. Youth with completed baseline and follow-up assessments demonstrated improvements across many domains including: improved symptom management, greater recovery orientation, increased sense of well-being, and reductions in impairment due to substance use.
3. After participating in JBU, youth typically increased their utilization of BHS outpatient and ACT program services and decreased their use of BHS crisis and acute care services (i.e., crisis stabilization, urgent outpatient visits, and PERT interactions).
4. While 33.3% (n=13) of the 39 discharged were able to achieve desired goals and successfully discharge from JBU (often directly to other behavioral health programs with a residential component), more than half (56.4%; n=22) were discharged from JBU prior to achieving objectives due to issues related to substance use disorders (SUD) that disrupted participation in services.

Additional Program Highlights

1. Enrolled youth were between the ages of 18-25 and racially diverse.
2. 100% of JBU enrollees had an SMI diagnosis (approximately 50% had a diagnosis of schizophrenia or bipolar disorder), and many had a history of co-occurring substance abuse.
3. JBU staff and external partners provided over 1,000 different group and individual holistic wellness services (e.g., meditation, biofeedback, yoga), or educational/enrichment activities (e.g., cooking classes, nature-based activities).
4. Participation in JBU holistic services was associated with improved sense of belonging, greater self-esteem and increased hopefulness for the future.
5. A total of 124 linkages to services were made across mental health, housing, and substance abuse domains, with multiple linkages per youth made to provide individualized treatment plans.

Conclusion

In addition to the emphasis on increasing awareness and practices of wellness among JBU youth, the program was successful at creating linkages to other BHS treatment programs, with 75% of youth participating in outpatient care while enrolled in JBU and approximately 25% of youth transitioning to ACT programs after completing the residential phase of JBU. The program also continued to evolve to address emerging issues to better meet ongoing needs of the youth they were serving, specifically that of mental health stabilization. Substance abuse was identified as a significant issue that disrupted youth engagement in JBU services and inhibited the achievement of program objectives. A more explicit focus on providing the education, supports, and treatment linkages needed to help address co-occurring substance use disorder (SUD) will be a priority for JBU during FY 2020-21.

Primary Recommendations for FY 2020-21

1. Focus program activities on improving youth comfort with and interest in participating in mental health treatment.
2. Proactively address factors that inhibit engagement in program services through holistic and other supportive services.
3. Develop additional strategies to improve JBU effectiveness among youth who have co-occurring SUD.

4. Re-locate program to a neighborhood with fewer negative environmental opportunities for engaging in undesired behaviors (e.g., less access to drugs).

Program Description

Using County of San Diego Behavioral Health Services (BHS) Electronic Health Record (EHR) data, BHS personnel identify youth (age 18-25) who appear eligible for JBU services (i.e., multiple acute/crisis related BHS service contacts, SMI diagnosis, and unconnected to behavioral health services). Once JBU receives these names from BHS, intensive outreach efforts are made by JBU staff to locate and contact each youth using available information provided by BHS, street searches, and coordination with other County and support agencies.

Once eligible youth have been contacted, given an explanation about the program's offerings, and agreed to enroll in the program, JBU provides short-term housing (i.e., up to 120 days), that incorporates support services, smart device-based apps and biometric technology, integrative medicine, and holistic health care in one central, urban location. With dormitory-style housing on one floor, JBU youth can access a centralized kitchen, cooking and nutritional classes, and holistic health care services and classes all within the same building in downtown San Diego. During their time in the program youth will receive recuperative, integrative, and holistic wellness services such as acupuncture, yoga, massage therapy, Reiki, chiropractic care, and meditation, as well as mindfulness education, biofeedback therapy, nutritional counseling, individual case management, peer support, group outings, and various in-house community-building trainings and events.

The overarching goal of JBU is to engage and stabilize youth by offering short-term housing while providing holistic youth-centric recuperative services. Throughout their residence at JBU, youth are linked with ongoing treatment, housing, and supportive services, thereby improving their mental health and quality of life in the community. Ideally, JBU programming breaks the cycle of homelessness early in the process, avoiding youth hardening in identity as homeless and mentally ill. This has the additional benefit of minimizing the tendency of this population to repeatedly utilize inappropriate and financially burdensome levels of emergency and mental health services.

The program's emphasis on community building, destigmatization of mental illness and homelessness, and active engagement in self-care through psychoeducation, self-regulation training, and engagement with holistic and integrative therapies both attracts and retains this historically difficult-to-reach cohort of the homeless population.

It is particularly salient that the program aims to intervene early in the cycle of homelessness, before youth self-identify as homeless and/or helpless, and before the personal and societal costs escalate and become more intractable. Further, the program's emphasis on destigmatization, community, and well-being provides a model of care and continuity that is characteristic of a well-functioning family, the historical foundation for ensuring safety, growth, and wellness in a well-functioning human society.

Service Changes Due to COVID-19

The COVID pandemic first affected the San Diego area in a substantial manner during March 2020. San Diego County issued a public health order effective 3/13/2020 to limit the size of public gatherings to less than 250 persons and to restrict access to hospitals and long-term care facilities serving seniors. This was followed by a statewide public health order on 3/19/2020 that required all non-essential workers to stay at home. During this time period, San Diego County BHS programs had to quickly adapt to the new service delivery environment to protect both client and staff safety while continuing to provide mental health services. For many programs, these changes included a switch to or greater utilization of telehealth services.

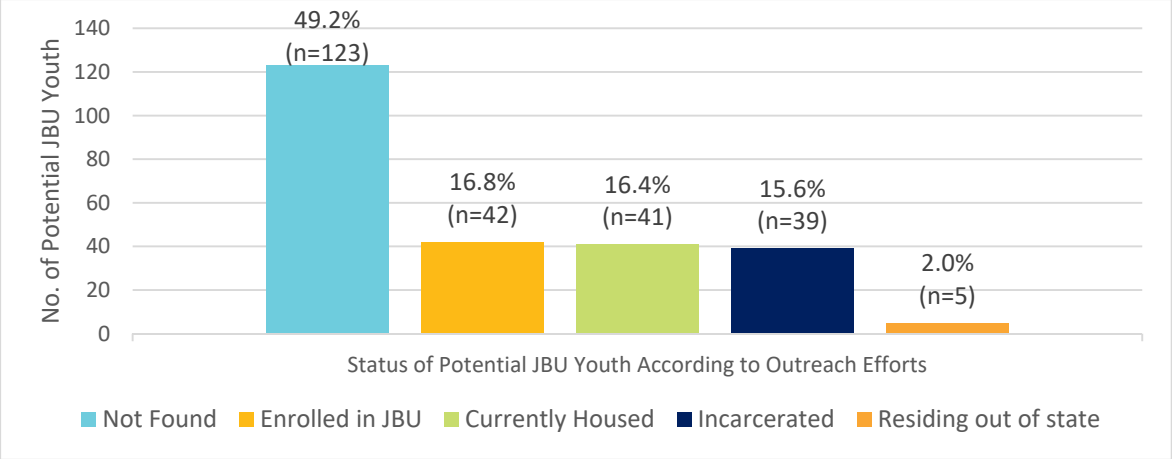
As a residential program serving a population at high risk for exposure to disease (i.e., homeless youth), JBU staff maintained in-person operations throughout the pandemic. JBU staff worked to ensure compliance with all CDC and San Diego County public health guidelines, such as holding staff safety procedure trainings, providing quarantine and isolation plans, increasing security and protocols for building entry, posting COVID-19 safety education materials, staff and youth mask requirements, rigorous sanitation procedures, and compliance with the "stay-at-home" order to prevent opportunities for exposure. While the basic residential component continued without interruption, JBU suspended all in-person holistic services except those which could be socially distanced or completed via remote technologies (i.e., yoga, fitness, mindfulness, and biofeedback). Public outings to promote education, enrichment, and/or growth with peers were also halted through the end of FY 2019-20. Sessions with behavioral health providers (e.g., from Areta Crowell Center) continued, but were moved to telehealth platforms. JBU staff facilitated sessions by setting up a computer for private video sessions with therapists and other external service providers.

Where relevant, findings and recommendations in this report underscore issues potentially related to the unique challenges that COVID-19 poses within the local community and healthcare environment.

Program Outreach and Enrollment

After JBU was notified of youth who appeared to meet the specific JBU eligibility criteria set by BHS personnel, substantial efforts were made by the JBU team to locate eligible youth who might benefit from the program. Where made possible by the availability of sufficient contact information or leads, outreach efforts were directly made to each youth. In all cases of eligibility, 100% of youth were sought out for contact. In the event of there being insufficient contact information, the JBU team attempted to reach youth through other means, such as by direct street canvasing, utilizing the BHS EHR system to alert other programs that the youth was potentially eligible for JBU services, contacting other key service providers connected to the youth (e.g., parole officers, jails, psychiatric hospitals, inpatient rehabilitation centers), and reaching out to other programs in San Diego County.

Figure 1. Status of Potential JBU Youth According to Outreach Efforts during FY 2019-20 (N=250)



Of the 250 youth determined by BHS to be potentially eligible during FY 2019-20, 49.2% (n=123) were unable to be reached by JBU due to an unknown location or inability to contact via information provided. Outreach efforts made by JBU staff highlight the difficulty in contacting this population, who are by definition unconnected to County services. Thirty-nine youth (15.6%) were found upon contact to be unavailable due to ongoing involvement with the criminal justice system. Of the remaining 88 youth, 41 (16.4%) were ineligible due to having established housing and five (2.0%) had moved out of state. Forty-two (16.8%) youth enrolled in the JBU program.

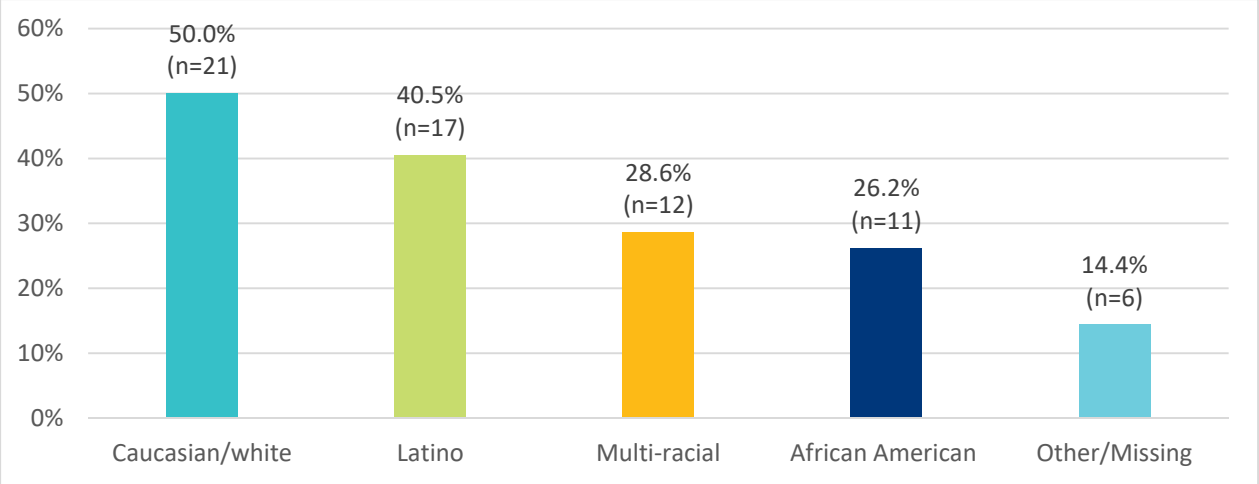
The distribution of JBU outreach and enrollment efforts highlight both challenges of locating potentially eligible youth (i.e., approximately 50% were not found) as well as the high level of interest in the services offered by JBU – fully 100% of the youth who were located and found to still be eligible enrolled into the JBU program. This suggests that that types of services offered by JBU and the manner in which JBU staff conduct their outreach communication has high levels of intrinsic appeal to youth. Of note, the 42 youth newly enrolled in JBU during FY 2019-20 represent a 90.1% increase in enrollment from the 22 enrolled during the prior "start-up" year.

Participant Characteristics

A brief overview of JBU participant characteristics is presented here with a more complete listing in the report appendix. JBU program eligibility criteria required that participants were youth between the ages of 18 and 25. Of the 42 youth who enrolled in JBU during FY 2019-20, the majority (n=30; 71.4%) identified as male. Almost all JBU youth, 92.9% (n=39), spoke English as their primary language, and 88.1% (n=37) identified as heterosexual or straight. None of the JBU youth indicated they had served in the military.

As shown in Figure 2, JBU youth were racially and ethnically diverse with no single population group representing more than 50% of the population. Note: Numbers may exceed 100%, as youth may select more than one racial identity.

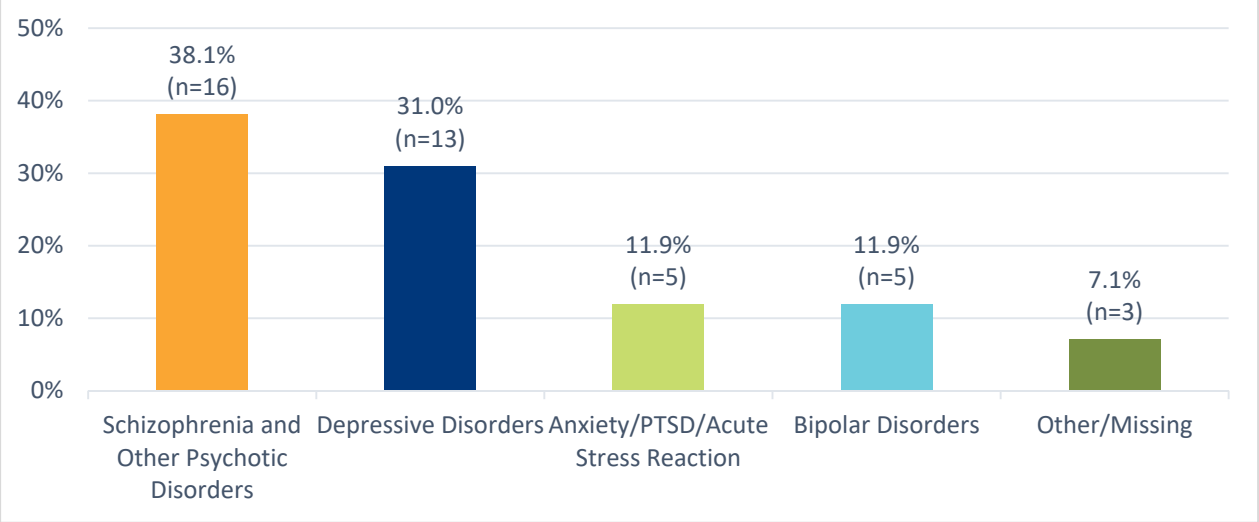
Figure 2. Race/Ethnicity of Youth Who Enrolled in JBU during FY 2019-20 (N=42)



Note: Total may exceed 100% since more than one race/ethnicity could be selected.

One of the eligibility requirements for JBU participation is the diagnosis of a serious mental illness (SMI). As shown in Figure 3, of the JBU youth enrolled during FY 2019-20, over 60% were diagnosed with Schizophrenia and Other Psychotic Disorders, or Bipolar Disorders. In addition (as discussed in other report sections below), there was a high prevalence of co-occurring substance abuse issues among JBU participants.

Figure 3. Primary Mental Health Diagnosis of Youth Who Enrolled in JBU during FY 2019-20 (N=42)



In response to the nearly 70% of youth with Depressive Disorders or Schizophrenia/Other Psychotic Disorders, JBU staff made substantial attempts to support the mental health needs of JBU youth and connect youth to appropriate community partners. More information on services linked to by JBU staff is available in this report.

Utilization of Program Services

Engagement in JBU Activities

In addition to the ongoing support and encouragement of the youth through daily personal interactions with JBU staff and peer supports during FY 2019-20, JBU offered 441 group and 594 individual structured activities that covered a range of holistic services and general living/educational events. Group outings had an average participation of four youth per session. Cooking classes and grocery shopping were also well attended group activities. Many of these activities were impacted by San Diego County Public Health orders in response to the COVID-19 pandemic. Social distancing mandates were in place, and outings to grocery stores and other public spaces were cancelled due to "stay-at-home" orders. These changes substantially reduced the number of activities that that would otherwise have been provided during FY 2019-20. Despite the limitations due to the pandemic, JBU programming demonstrated extensive opportunities to connect with, enrich, and promote well-being among youth. As discussed in more detail in Key Evaluation Findings—Additional Outcome Measures, in addition to promoting relationship and skill-building, participation in these activities also achieved changes in personal well-being including greater self-esteem and a more hopeful outlook for the future.

Figure 4a. JBU Sponsored Group Activities (N=441)

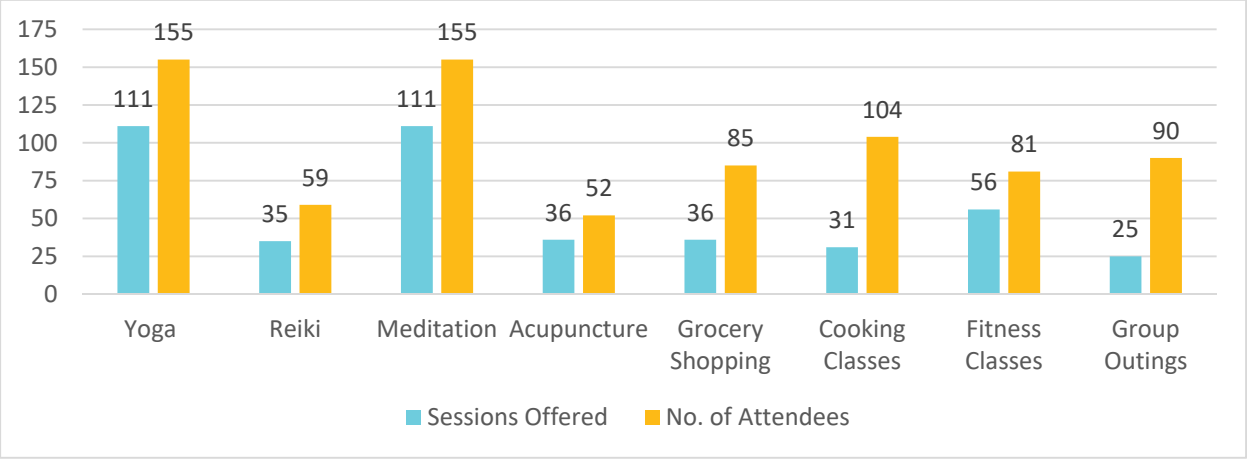
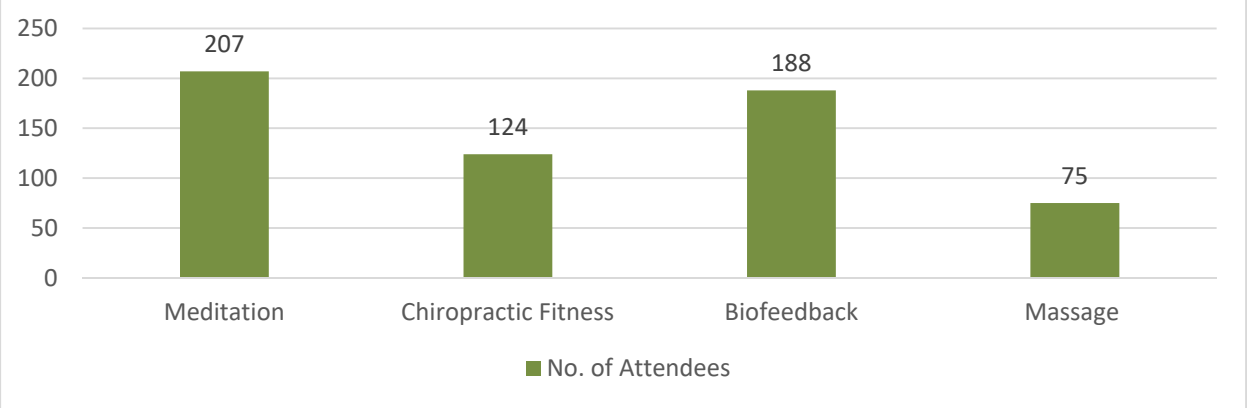


Figure 4b. Youth Attendance in JBU Sponsored Individual Activities (N=594)

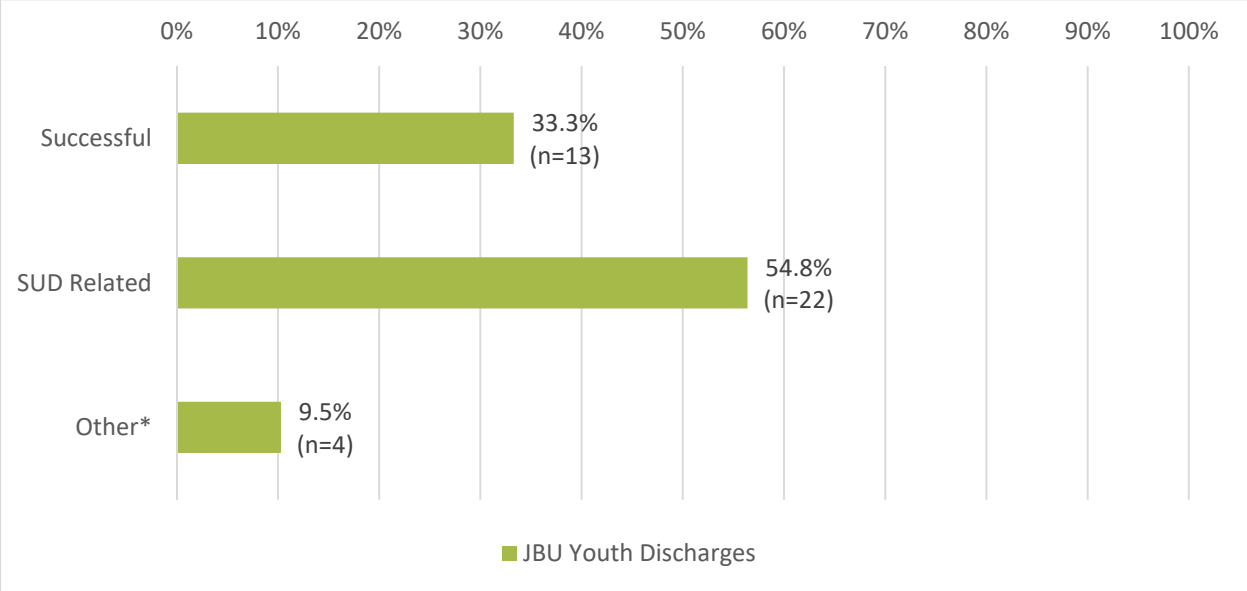


Retention

JBU enrolled a total of 42 individuals in services during FY 2019-20. Of these youth, 33 (78.6%) disengaged from services at least once during their time at JBU. Primary reasons for disengagement included declining need for services, SUD-related challenges that disrupted participation, or a exhibiting a need for more intensive inpatient/residential SUD or mental health treatment. In an attempt to maintain relationships and connections with youth and re-integrate them into services, JBU developed a flexible return-to-JBU policy tailored to the unique circumstances of the individual youth. This personalized approach allowed for 10 youth (30.3% of those who to disengaged) to return to the JBU program after they satisfied the conditions of their return. Most of the youth who disengaged and then returned to JBU had a gap in services of 7 days or less, but for some the gap was longer than 30 days. For a select few youth, disruption of services occurred multiple times. Individual follow-up discussions were offered to each youth who disengaged to identify specific re-entry criteria and encourage each youth to address any behavioral challenges related to the disengagement issue(s).

Of the 42 youth enrolled during FY 2019-20, a total of 39 had been discharged as of 6/30/2020. As shown in Figure 5, of those who were discharged, 33.3% (n=13) of the youth were discharged from the JBU program after successfully completing their goals and/or transitioning on to other treatment services. However, the majority were discharged prior to achieving desired objectives, with SUD-related issues as the primary factor for discharge (56.4%).

Figure 5. Primary Reasons for Discharge from JBU during FY 2019-20 (N=39)



**Other includes: declined services, SMI impairment, damaging facilities, etc.*

This discharge data highlights that while JBU was able to accomplish positive goals with many of the youth who entered the program, comorbid SUD-related challenges presented a formidable obstacle. The SUD-related challenges disrupted the potential of widespread engagement of these youth in the core objectives of promoting wellness and connecting youth to appropriate treatment. More explicit attention to addressing co-occurring SUD-related challenges of youth will be a priority during FY 2020-21.

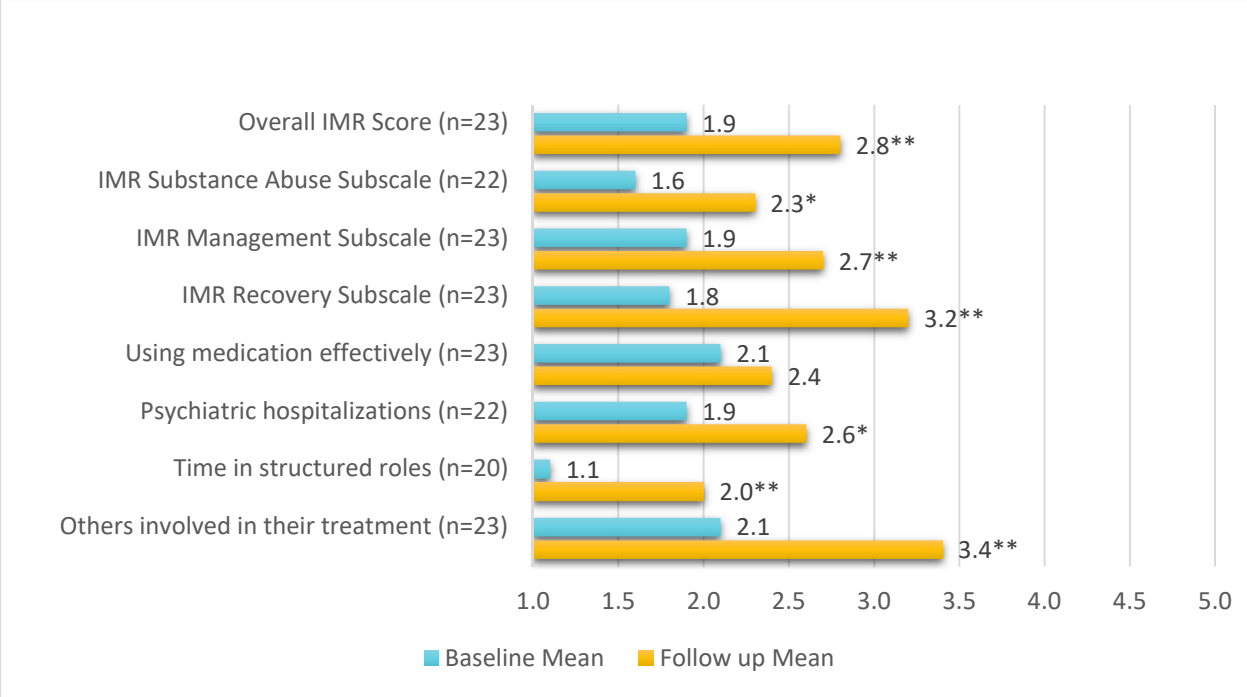
Key Evaluation Findings – BHS Outcome Measures

The following sections highlight outcomes for youth gleaned via assessment tools completed upon intake into the JBU program and at least during one follow-up time point (i.e., assessments are administered monthly during the residential phase of JBU). In situations where a youth may have multiple completed follow-up assessments, the most recently completed assessment (prior to end of FY on 6/30/2020) was used in the analysis. The requirement to have at least two data points allows for examinations into changes that might occur while enrolled in JBU, however, this also reduces the sample size included in the analyses. Two primary reasons exist for not having completed follow-ups. First, for measures based on youth self-report, not all youth choose to complete the voluntary self-assessment tools at the follow-up time point(s). Second, youth may leave the program prior to a follow-up assessment, which precludes obtaining youth self-report measures. Further, in some cases there may also be insufficient information for staff to complete the staff-reported measures. These data collection challenges are not unique to JBU as evidenced by the Mental Health Outcomes Management System (mHOMS) Annual Outcomes Report for FY 2018-19 (the most recent version available for comparison), which indicates that less than one-third of clients in BHS programs throughout San Diego County have completed the standard client self-reported and staff-reported outcome measures. The primary implication of this circumstance is that the findings presented below may not generalize to the subset of JBU participants for whom follow-up data is unavailable. Investigations into the generalizability of the findings to all JBU participants will be examined in future reports as the cumulative number of JBU participants increases and allows for more definitive conclusions.

Illness Management and Recovery Scale (IMR)

To measure staff perception of client recovery, the Illness Management and Recovery (IMR) scale was completed by JBU staff. The IMR has 15 items, each addressing a different aspect of illness management and recovery. Each item can function as a domain of improvement. Additionally, there are three subscales known as Recovery, Management, and Substance Abuse. IMR scores range from 1 to 5, with 5 representing the highest level of recovery.

Figure 6. IMR Results for JBU Youth with Follow-up during FY 2019-20 (N=23)



**Indicates statistically significant change with a p-value less than or equal to 0.05; **Indicates statistically significant change with a p-value less than or equal to 0.01*

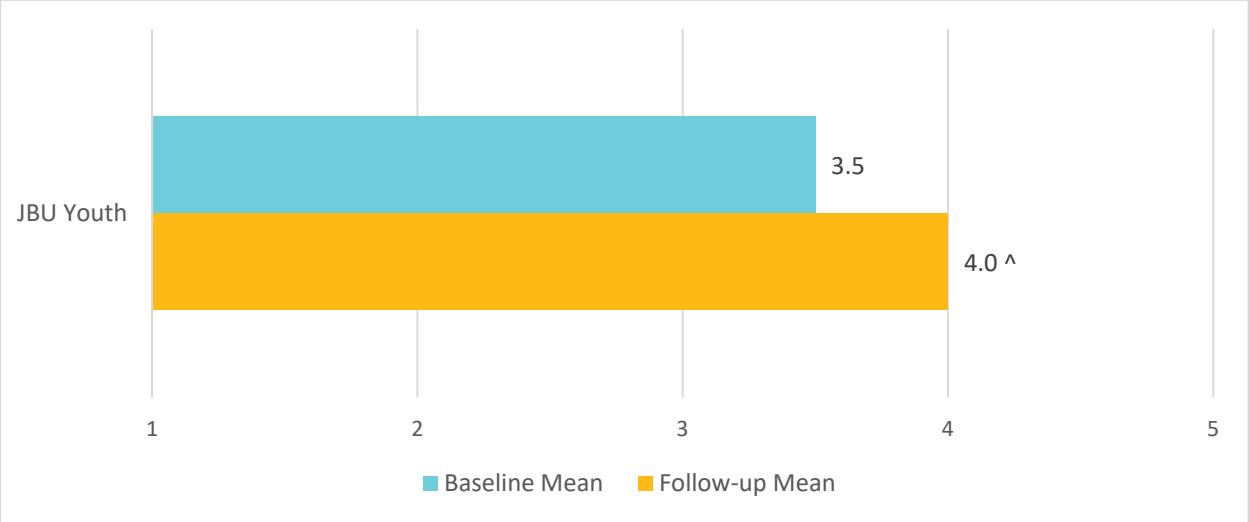
The overall IMR and subscale scores indicated relatively high levels of impairment across many dimensions with average intake IMR values typically 2 or less out of a 5-point scale. However, all items indicated improvements at follow-up (i.e., average scores across the items and scales ranging from 2.0 to 3.4 out of a 5-point scale).

As reported in the mHOMS Annual Outcomes Report for FY 2018-19 (the most recent version available for comparison), the average overall IMR score for other BHS programs was 2.8 at intake and 3.3 at follow-up. These values indicate higher levels of impairment for participants entering JBU than reflected in the systemwide BHS average (i.e., 1.9 compared to 2.8 at intake). While the Management Subscale for other BHS programs mirrored JBU values of 1.9 at baseline and 2.7 at follow-up, the Recovery Subscale among other BHS programs reported a higher average intake score (2.4) and lower average follow-up score (3.0) than found for JBU participants. This suggests that JBU was able to obtain substantial improvements among participants who were generally less recovery-oriented at intake. The greatest area of difference between JBU and other BHS program participants at intake was found within the IMR Substance Abuse (1.6 and 4.7, respectively). This demonstrates the high prevalence of and substantial levels of impairment due to substance abuse among JBU participants, which is consistent with ongoing staff reports. Improvements were evident at follow-up (2.3) but remained well below system-wide average of 4.8. The overall pattern of JBU IMR results indicated that positive changes were typically achieved – across multiple illness management and recovery domains – while receiving JBU services.

Recovery Markers Questionnaire (RMQ)

The RMQ is a 26-item questionnaire that assesses elements relevant to mental health recovery from the client's perspective. It was developed to provide the mental health field with a multifaceted measure of personal recovery. The results listed below have been rescaled to the following: 1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; and 5 = Strongly Agree, with higher values corresponding to higher levels of well-being. The RMQ asks youth to answer questions from the perspective of what is "true for you now."

Figure 7. RMQ Results for JBU Youth with Follow-up during FY 2019-20 (N=18)



^Indicates a statistically significant change at a p-value less than or equal to 0.10

As shown in Figure 7, overall RMQ mean scores improved from baseline to follow-up (3.5 to 4.0). As reported in the mHOMS Annual Outcomes Report for FY 2018-19, the average RMQ at intake for other BHS treatment programs (e.g., outpatient, ACT, case management, and youth residential programs) was 3.4. It appears that JBU participants self-report similar assessments of their recovery status and outlook on life as do clients in other BHS programs upon entry into JBU. However, the average follow-up RMQ score for JBU participants (i.e., 4.0) increased to a level higher than the average follow-up RMQ scores reported by other BHS programs (i.e., 3.7).

Figure 8. IMR and RMQ Results for JBU Youth with Follow-up during FY 2019-20

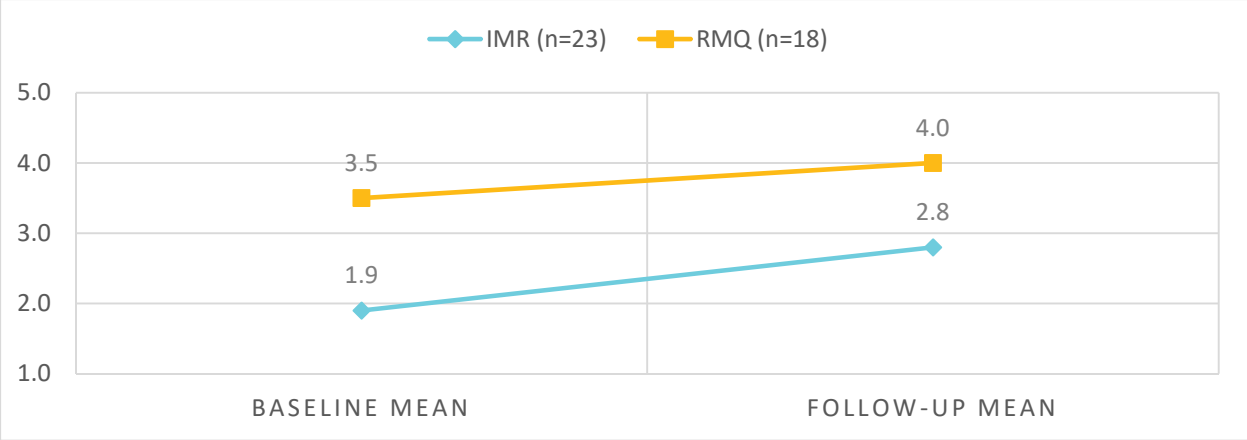


Figure 8 highlights a similar trend line in recovery reporting from both youth and staff reported measures, an indication of the reliability and validity of the data.

Milestones of Recovery Scale (MORS)

The Milestones of Recovery Scale (MORS) captures the stage of mental health recovery, as assessed by staff, using a single-item recovery indicator. Participants were placed into one of eight stages of recovery based on their level of risk, level of engagement within the mental health system, and the quality of their social support network. Raters are instructed to select the level describing the typical milestone of recovery that an individual displayed over the previous month, with higher MORS ratings indicate greater recovery.

Table 1. MORS Results for JBU Youth with Follow-up during FY 2019-20 (N=24)

		Baseline		Last Follow-Up	
Value	**MORS Category**	**N**	**%**	**N**	**%**
1	*Extreme risk*	2	8.3%	0	0.0%
2	*High risk, not engaged*	5	20.8%	0	0.0%
3	*High risk, engaged*	2	8.3%	1	4.2%
4	*Not coping, not engaged*	12	50.0%	2	8.3%
5	*Not coping, engaged*	3	12.5%	9	37.5%
6	*Coping/rehabilitating*	0	0.0%	10	41.7%
7	*Early recovery*	0	0.0%	1	4.2%
8	*Advanced recovery*	0	0.0%	1	4.2%
	Unique N	24	/	24	/
	Mean MORS	**3.4**		**5.5****	
**Indicates statistically significant results at a p-value less than or equal to 0.01					

The results indicate substantial changes in recovery status at follow-up. At intake, no youth were considered as coping or in recovery, whereas fully 50% were doing so at follow-up, and an additional 37.5% were at least engaged in efforts to improve their mental health.

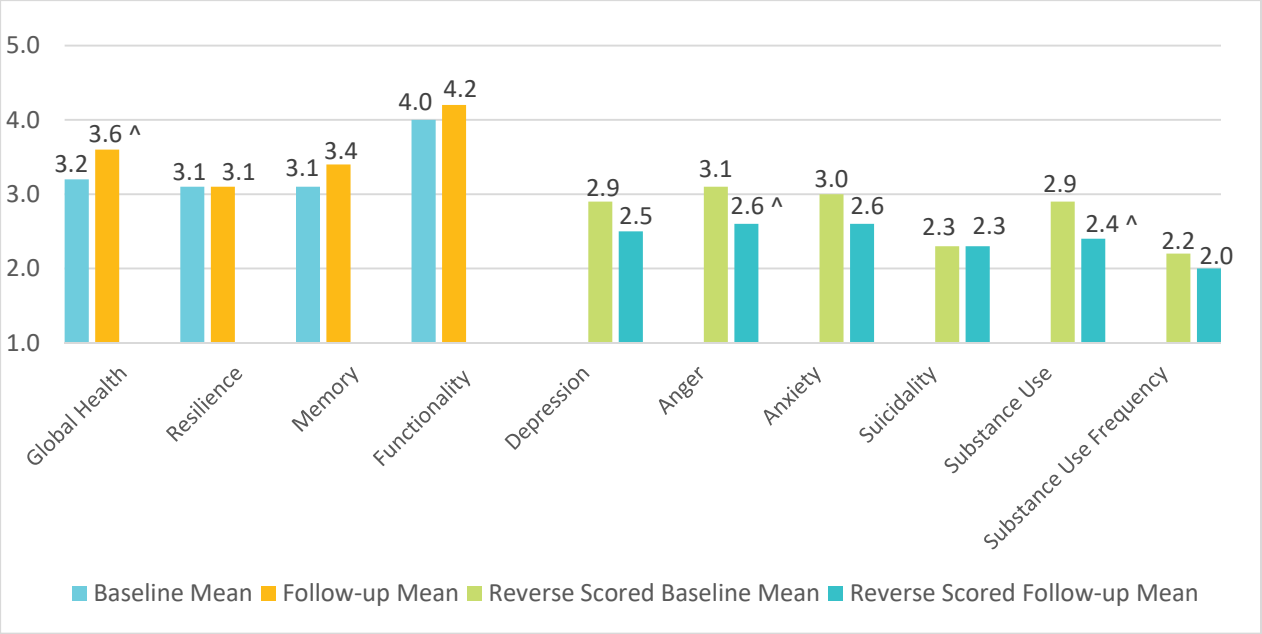
As reported in the mHOMS Annual Outcomes Report for FY 2018-19 (the most recent version available for comparison), the average MORS score for other adult BHS programs was 4.4 at intake and 4.9 at follow-up. The findings from JBU indicate that youth typically entered the program with a lower-than-average MORS score (i.e., more impaired/less engaged in treatment), but had a higher-than-average MORS score at follow-up (i.e., less impaired/more engaged in treatment). The lower-than-average MORS score at intake was consistent with the JBU focal population (i.e., youth with serious mental illness who were not currently in or seeking treatment), with the substantial positive change in MORS score suggesting a high capability of the JBU team to support and connect with youth and get them linked to appropriate levels of treatment.

Key Evaluation Findings – Additional Outcome Measures

CHAMPSSS

The CHAMPSSS is completed by the youth and assesses youth perceptions and experiences that indicate recovery, symptom reduction, and increased self-esteem. Scores range from 1 to 5 and items were coded as follows: Global Health, Resilience, Memory, and Functionality subscales were coded so a higher score indicated a more desirable outcome (1=least desirable and 5=most desirable). The Depression, Anger, Anxiety, Suicidality, Substance Use, and Substance Use Frequency subscales were coded so a lower score indicated a more desirable outcome (1=most desirable and 5=least desirable). Scales were coded in this manner to facilitate a more intuitive interpretation of the results.

Figure 9. CHAMPSSS Results for JBU Youth with Follow-up during FY 2019-20 (N=18)



^Indicates a statistically significant change at a p-value less than or equal to 0.10

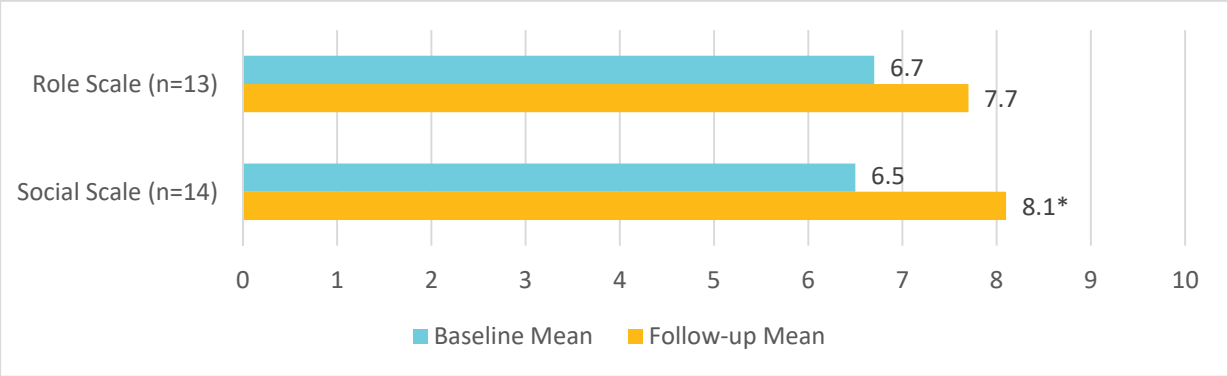
The CHAMPSSS findings demonstrated improvement in many different aspects of well-being from baseline, with statistically significant differences identified among the domains of Global Health, Anger,

and Substance Use subscales of the CHAMPSSS. Changes were not seen across the Resilience nor Suicidality subscales.

Global Functioning

Following a semi-structured interview, the provider rated the Role and Social Functioning of JBU youth on a 10-point scale (1 = Extreme Dysfunction; 5 = Serious Impairment; 10 = Superior Functioning).

Figure 10. Global Functioning Results for JBU Youth with Follow-up during FY 2019-20



**Indicates a statistically significant change at a p-value less than or equal to 0.05*

For both scales, baseline mean values were typically in the 3-5 range (indicative of substantial impairment). Follow-up mean values increased to over 7.5, which is indicative of mild impairment/good functioning. Improvement in the Social Scale was statistically significant for JBU youth.

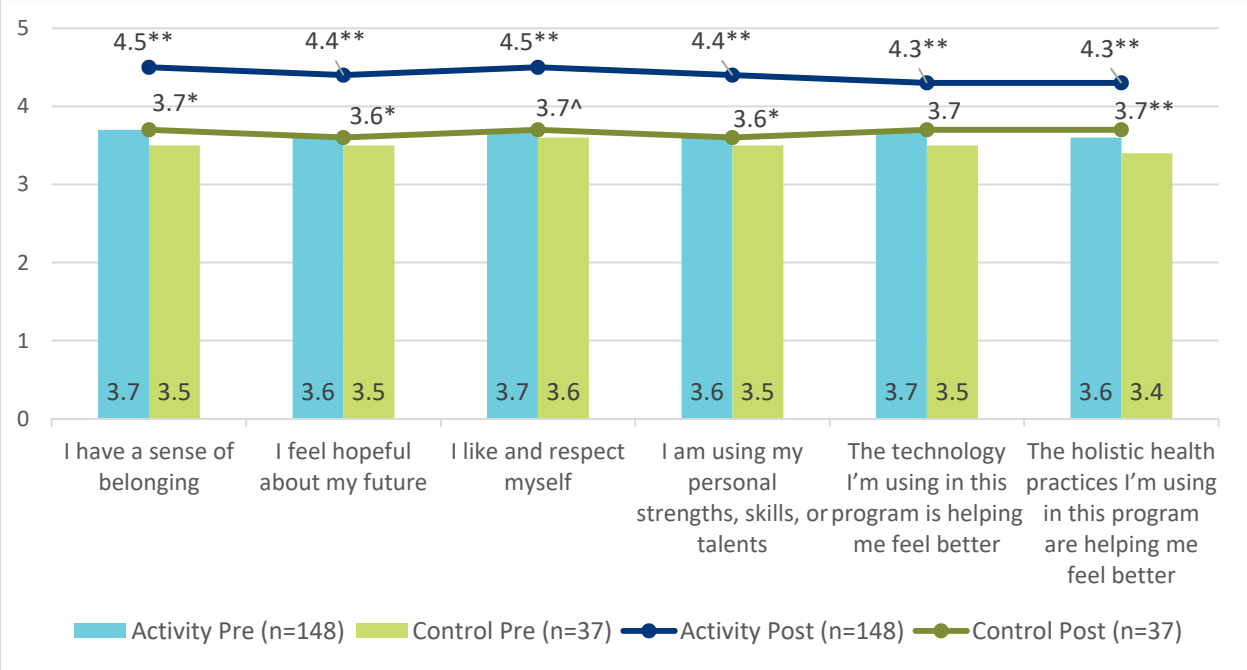
Pre/Post Holistic Practice Assessment

In addition to the goal of promoting engagement, the holistic activities supported by JBU programming are designed to achieve changes in skill-building, address social skills, and increase personal well-being including greater self-esteem and a more hopeful outlook for the future. While some of these outcomes are measured in the longer-term, JBU and the evaluation team identified mood and positive thinking as one component which could be measured immediately.

To help identify whether participation in the holistic activities was directly associated with at least short-term improvements in mood and positive thinking, youth answered the six questions listed in Figure 11 on multiple occasions – typically before and after participating in a JBU-provided holistic practices including: yoga (n=31), reiki (n=15), massage (n= 34), chiropractic care (n=24), biofeedback (n=32), and acupuncture (n=12).

Occasionally, they were asked the questions without having a corresponding activity occurring in between question administrations, to generate "control/no activity" data for comparison purposes. The results listed below have been rescaled to the following: 1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; and 5 = Strongly Agree. Higher values correspond to higher levels of well-being and/or positive perceptions.

Figure 11. Pre-Post Holistic Practice Assessment for JBU Youth with Follow-up during FY 2019-20



*^Indicates a statistically significant change at a p-value less than or equal to 0.10; *Indicates a statistically significant change at a p-value less than or equal to 0.05; **Indicates a statistically significant change at a p-value less than or equal to 0.01*

Overall, there was a pattern of more favorable ratings after participating in a holistic practice with pre-tests averages of 3.6 or 3.7 on a 5-point scale and post-test averages ranging from 4.3 to 4.5, for a typical change of nearly a full point increase (~0.8) in well-being after participation.

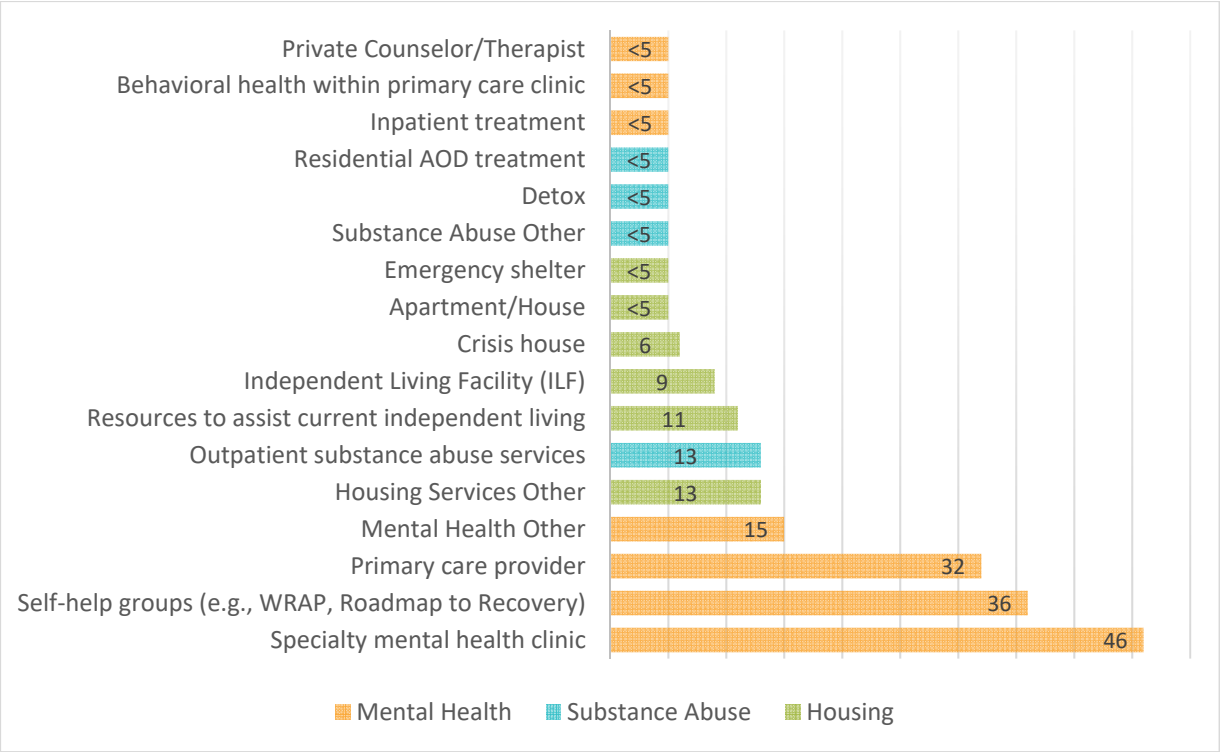
By contrast, changes were either not evident or minor when no activity occurred between question administrations (i.e., typically change of approximately 0.2). Additionally, the data suggest the potential for an anticipatory priming effect in that "pre" values were higher when participation in holistic activities was expected than during the no activity controls. These findings suggest that there are positive changes in youth attitudes about themselves and their future due to participating in the range of holistic services provided through JBU.

Linkages to Services

The following tables indicate the linkages to external community services made across several key domains: mental health, substance abuse, and housing. These linkages were facilitated by JBU staff according to the individual and unique needs of each youth. In total, 124 linkages were made, with 73 of the linkages (58.9%) connecting youth to mental health services. Of substance abuse linkages (n=19), 13 (68.4%) were to residential or outpatient substance abuse services.

These linkages are consistent with other evaluation data points indicating substance abuse as a substantial issue facing JBU youth. Totals may exceed 100% due to multiple linkages. Figure 12 reflects linkages across different domains.

Figure 12. Linkages to External Services during FY 2019-20 (N=124)



In stakeholder meetings throughout FY 2019-20, increased access to residential SUD and mental health treatment programs were most cited as factors that would benefit the program.

BHS Utilization Patterns

San Diego County BHS Services 90 Days Before, During, and 90 Days after JBU

BHS utilization patterns before, during, and after leaving the residential portion of JBU can help identify the extent to which participation in JBU is associated with a changing mix of service utilization (i.e., increased engagement in treatment and reduced interaction with crisis/acute care). The following analyses were accomplished by reviewing the electronic health record that documents county-funded BHS services provided throughout San Diego County to identify other mental health services received by JBU participants. Given the variable length of time that a youth might be in the residential portion of the JBU program, a standardized metric was created to enable equivalent comparisons for the three time periods of interest. The standardized metric for the "during JBU" period reflects the average amount of service JBU youth would be expected to receive during a 90 day stay with JBU. This metric facilitates comparisons to the 90-day period immediately preceding JBU enrollment and the 90-day period after leaving the residential phase of the JBU program.

The standardized "during JBU" metric was computed by summing the total number of BHS services (by service type) that occurred while the youths were enrolled in JBU and dividing that by the total number of days that all youth were enrolled in JBU. The resulting values represents the average number of each specific BHS service that a JBU youth received per day, which is then multiplied by 90 to generate the estimate of BHS services that JBU youth would receive during a typical 90 days in JBU. For the 90 days

prior to JBU, all BHS services (by service type) were summed and then divided by the total number of JBU clients to generate an estimate of the average number of BHS services received by JBU clients prior to enrolling in JBU. A similar calculation was made for the 90-day period after youth left the residential phase of the JBU program. The analyses include JBU participants who enrolled in both FY 2018-19 and FY 2019-20 as long as they had been discharged at least 90 days before the end of FY 2019-20 to ensure full and equivalent 90-day "post-JBU" observation periods for all persons.

As shown in Table 2, the 53 JBU youth included in these analyses had either no or very limited involvement with BHS outpatient services in the 90 days prior to entering JBU (average of 0.4 outpatient sessions across all youth). However, that changed substantially during their time in JBU as many more youth linked to outpatient care and the 90-day average number of outpatient sessions increased to 9.6. After leaving the residential phase of JBU, outpatient visits remained more prevalent than pre-JBU but decreased to an average of 2.1 sessions per youth. This apparent reduction in outpatient services 90 days post-JBU is likely partially explained by the linkages to ACT programs that JBU was able to accomplish for many youth while in the JBU program. Fully 26.4% (i.e., 14 out of 53), of JBU youth had ACT visits post JBU, with the average number of sessions increasing to 4.3 from 2.0 during JBU and none pre-JBU.

Table 2. BHS Service Utilizations Patterns Before, During, and After JBU Participation[1] (N=53)

	90 Days Prior to JBU Enrollment			Standardized 90 Days During JBU Residential Phase			90 Days After Leaving JBU Residential Phase		
	% of youth	# of visits/ episodes	Average per JBU youth	% of youth	# of visits/ episodes	Stdzd. average per JBU youth	% of youth	# of visits/ episodes	Average per JBU youth
Outpatient	11.3%	21	0.4	75.5%	422	9.6	49.1%	109	2.1
ACT	0.0%	0	0.0	24.5%	86	2.0	26.4%	229	4.3
Urgent Outpatient	39.6%	36	0.7	41.5%	25	0.6	22.6%	13	0.2
PERT	28.3%	19	0.4	13.2%	9	0.2	13.2%	11	0.2
Crisis Stabilization	26.4%	21	0.4	0.0%	0	0.0	9.4%	5	0.1
Inpatient	30.2%	27	0.5	18.9%	15	0.3	20.8%	21	0.4
Crisis Residential	20.8%	14	0.3	13.2%	7	0.2	11.3%	9	0.2

[1] *Note: the percent of youth and number of visits/episodes columns are not directly comparable across all three time periods since the average length of time during JBU was less than 90 days (i.e., mean = 75 days). Only the average column is directly comparable across all three time periods.*

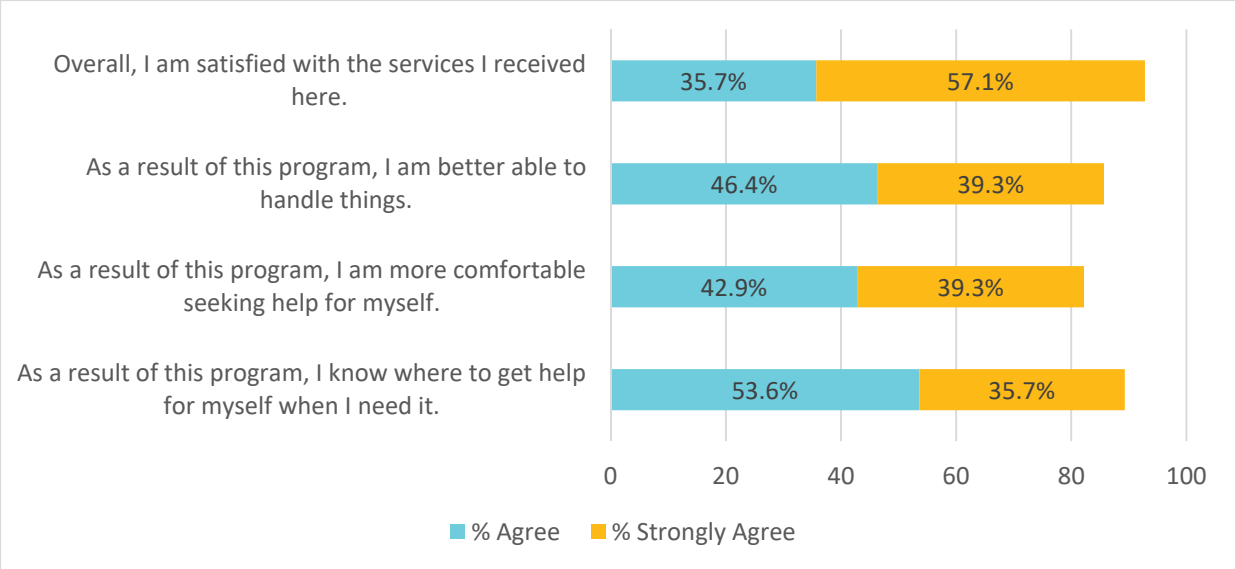
The patterns evident among acute/crisis-oriented type BHS services were more nuanced, but overall suggested a trend towards a reduction in need for such services. Interestingly, the average number of urgent outpatient visits was similar before and during JBU (0.7 and 0.6, respectively), but was substantially lower post-JBU (0.2). This is consistent with JBU staff facilitating access to needed urgent outpatient care among youth during JBU as part of treating their illness and avoiding more serious situations that might

require a crisis stabilization visit (none occurred during JBU) or an inpatient hospitalization (fewer occurred during JBU than pre-JBU). For all crisis/acute care services, the number of youths accessing these services post-JBU was less than the number pre-JBU. While caution is warranted when interpreting findings with relatively small sample sizes, reductions in the total number of youth and/or average service counts between pre-JBU and post-JBU were 40% or more for urgent outpatient, PERT, crisis stabilization and crisis residential. Overall, these findings provide evidence of increased connections to outpatient and ACT treatment services and a corresponding decrease in crisis and acute care service utilization resulting from JBU participation.

Youth Perspectives on JBU Services

A total of 28 youth completed feedback surveys at one of the follow-up time periods during FY 2019-20. As shown in Figure 13, approximately 80-90% of youth agreed/strongly agreed that as a result of participating in JBU they knew where to get help when needed (89.3%), were more comfortable seeking help (82.2%), and were better able to handle things (85.7%). Over 90% (92.8%) indicated that they were satisfied with the services they received from JBU with 57.1% indicating strong agreement. Overall, these finding suggest that among youth who completed a follow-up assessment, there was widespread acknowledgement of achieving key JBU program outcomes of increasing youth knowledge of how to access services, reduced stigma associated with accessing services, and an increased sense of being better able to manage themselves.

Figure 13. JBU Services Feedback Questions for FY 2019-20 (N=28)



Program Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings and 2) the Annual JBU Staff Survey. The stakeholder meetings were held throughout the year with representatives from BHS, JBU, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual JBU Staff Survey was conducted at the end of FY 2019-20. JBU program staff were asked to participate in a brief

online survey about their experiences with, perceptions about, and recommendations for the program. There were 10 respondents from the 10 JBU staff invited to participate in the survey (a 100% response rate). For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses, and any discrepancies found were discussed to arrive at a consensus on the key response themes.

Outreach and Recruitment of Potential JBU Participants

Reaching underserved youth was a primary goal of the JBU program, as identified by staff in the Annual Survey. Staff also indicated that locating youth identified for JBU participation proved difficult, but the program shifted outreach efforts to address that particular challenge. In collaboration with BHS, JBU developed an outreach plan to include youth who may have dropped off the county provided list of names but were still in need of housing services.

Environmental Influences

Based on feedback from JBU staff, the location of JBU in San Diego's downtown presented a substantial barrier to stabilization for JBU youth. Access to illicit drugs near JBU proved a challenge for youth attempting to remain sober. JBU staff indicated moving to a location where fewer environmental challenges existed that could potentially benefit youth.

Engagement and Retention of JBU Participants

Ultimately, JBU staff felt the program was designed to provide social and logistical support to youth to properly function in the "outside" world. One way in which the staff felt they were able to provide this support was through the personal relationships staff made with JBU youth. Overwhelmingly, JBU staff reflected on the important skill among their staff colleagues of engaging and retaining JBU youth. Additionally, staff reported that their connections to community partners helped JBU provide the services necessary for JBU youth to remain engaged in services.

In collaboration with BHS partners, the JBU in-residence service period was extended from the original 90-day period to a 120-day period to accommodate timeframes for key linkage implementation (e.g., housing, SUD training, SMI stabilization).

SUD and Participation in Mental Health Treatment

In response to program observations from FY 2018-19, JBU brought in SAY San Diego lecturers to speak to JBU youth during mandatory sessions regarding SUD. Additionally, JBU sought funding through Proposition 64 to provide a SUD training program, as well as training in the Restorative Talking Circles (RTC) format. JBU plans to integrate the RTC format into future sessions with JBU youth, providing opportunities for youth to develop marketable skills, as well as address issues with SUD. In order to proactively address co-occurring mental health and SUD-related issues, all youth were encouraged to connect with community partner therapists and psychiatrists to establish individualized treatment plans. Pill organizers, reminder contracts, and appointment compliance efforts were utilized with a majority of youth. JBU staff also suggested youth may want to consider discussing long-acting inhibitors (LAIs) with mental health professionals as a potential mechanism to support medication adherence where youth

reported unfilled prescriptions, inconvenience, or forgetfulness was a consistent reason for non-adherence.

Other Program Services

JBU has also combined Occupational Therapy (OT) sessions with SUD programming to best serve the needs of youth. Integration of OT interns, overseen by Dr. Bianca Doherty, resulted in group-facilitated and one-on-one sessions, focusing on skills such as socialization, emotional intelligence, and job-seeking/readiness skills.

JBU partnered with clinicians from The Jane Westin Center, who were on-site at least bi-weekly to provide youth psychiatric evaluations and prescriptions for medications as needed. This on-site service also scheduled youth for intake appointments at Areta Crowell Center if needed.

Nature outings and experiences were also included in JBU programing during FY 2019-20, including day hikes and overnight stay in Alpine mountain campgrounds. A garden project was initiated with youth input, for construction in courtyard of USA's main building. The concept of nature as a paradigm is reinforced in nutrition classes, cooking events, and kitchen work opportunities, and during weekly biofeedback/mind-body skills training. Youth were taken on a camping trip to Harrison Serenity Ranch at Palomar Mountain, an event which will continue on a semi-annual basis.

Additionally, JBU has partnered with a new app designer to better serve the needs of youth and the evaluation team. The holistic service of Reiki was discontinued.

Experiences with Telehealth Services

JBU staff who engaged with youth via telehealth reported approximately 15% of youth were consistently unable to utilize telehealth with video services. Approximately 20% of telehealth sessions experienced tech-based difficulties (i.e., dropped/poor connections, difficulties with devices, etc.). Staff providing services via telehealth reported JBU youth were willing to attend and schedule sessions via telehealth.

Individual providers reported different levels of youth responses to telehealth: some observed that certain youth struggled to engage and remain focused during the session, while others observed excellent engagement characterized by an increased sense of confidentiality during sessions and youth willingness to share personal information that was both unexpected and consistent. Utilization of telehealth technology may be modality- and/or provider-specific, such that some services and some providers are better able to leverage this form of service provision. Overall, staff indicated that utilization of telehealth services should continue to be a high priority for the program even after in-person services become safe and available again.

Additionally, the increased reliance upon telehealth services brought about by the COVID-19 pandemic has resulted in a wider range of community organizations and individual service providers now offering telehealth services. This expanded set of available telehealth services created opportunities for JBU youth to access services that would previously have been more difficult or impossible to obtain in-person.

Impact of COVID-19 on Program Staff

Overall, staff members indicated there were aspects of their lives, both related to work and unrelated to work, which changed due to the COVID-19 pandemic. JBU staff overwhelmingly indicated they experienced an increase in stress or anxiety due to COVID-19 and the response to the pandemic. Staff members reported coping with this increase in stress by using yoga, meditation, mindfulness, and healthy sleep practices. Of note, these are many of the services JBU staff provide to youth as part of the holistic service delivery. Staff also reported other changes in their roles and work-related tasks due to COVID-19.

Program Changes from Initial Design

After reviewing outcome data and collecting experiences of JBU youth, JBU stakeholders recognized those finding success in the program were typically engaged in services for a longer period of time. In discussions with BHS, it was decided to extend the in-residence phase of the JBU program from 90 days to 120 days. Also, to increase the number of youth enrolled in JBU, it was determined that in addition to the list of potentially eligible youth provided to JBU by BHS, youth identified through JBU outreach efforts and/or referrals from other community partners could also be admitted into JBU as long as they exhibited similar characteristics and histories as youth on the BHS list (i.e., SMI diagnosis, homeless, utilization of BHS crisis/acute services, and not engaged in treatment). This change will be fully implemented during FY 2020-21.

Program Recommendations

During FY 2019-20, the issues of mental health stabilization and addressing SUD continued to be highlighted as priorities for program staff. Holistic/integrative services were considered to be insufficient alone to address severe mental illness, especially when exacerbated by non-adherence to prescription medications and co-occurring SUD. As such, JBU staff recommend addressing the following during FY 2020-21:

1. Focus program activities on improving youth awareness of their own mental health needs and increasing openness to engaging in mental health treatment.
2. Proactively address factors that inhibit engagement in program services through holistic and other supportive services.
3. Develop additional strategies to improve JBU effectiveness among youth who have co-occurring SUD.
4. Re-locate program to a neighborhood with fewer negative environmental opportunities for engaging in undesired behaviors (e.g., less access to drugs).

Conclusion

During FY 2019-20, the second year of program operations, JBU was able to conduct outreach to and successfully enroll 42 youth who met all eligibility requirements (a 90.1% increase in enrollment from the prior year). Coupled with having an SMI, many of the youth also had substance use and abuse issues. JBU staff provided daily encouragement and support throughout the residential phase of the program as well as offering 441 group and 594 individual sessions for various holistic services and educational/enrichment activities. In addition to the emphasis on increasing awareness and practices of wellness among JBU youth,

the program was successful at creating linkages to other BHS treatment programs, with 75% of youth participating in outpatient care while enrolled in JBU and approximately 25% of youth transitioning to ACT programs after completing the residential phase of JBU. While access to external holistic providers was more limited as a direct response to the COVID-19 pandemic, the JBU staff continued to provide residential care services and facilitated telehealth connections to outpatient treatment providers.

For youth with baseline and follow-up outcome assessment data, both the staff self-report and the youth self-report measures indicated positive changes related to numerous domains, such as: improved symptom management, greater recovery orientation, increased sense of well-being, and reductions in impairment due to substance use. Staff feedback indicated that for youth who were not successfully engaged in JBU services, substance abuse was a primary factor that impeded their efforts. These experiences prompted the JBU program to create additional community connections and develop internal resources to better address substance abuse issues among youth enrolled in the JBU program. Overall, the findings from FY 2019-20 indicated that the JBU program was able to achieve key program objectives of outreaching to and engaging with their target youth population, creating linkages to appropriate mental health and substance use treatment, and improving the general well-being of the youth who participated in JBU services. The program also continued to evolve to address emerging issues to better meet ongoing needs of the youth they are serving, specifically that of mental health stabilization. Substance abuse was identified as a significant issue that often disrupted youth engagement in JBU services and inhibited the achievement of program objectives. As such, a more explicit focus on providing the education, supports, and treatment linkages needed to help address co-occurring SUD will be a priority for JBU during FY 2020-21.

For more information about this Innovation program and/or the report please contact:
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Appendix

Characteristics of Participants who Enrolled during FY 2019-20

Characteristic	Total Participants (N=42)	
Gender	N	%
Male	30	71.4%
Female	10	23.8%
Another Gender Identity/Missing	2	4.8%
Total	42	100%
Age Group	N	%
18-21	20	47.6%
22-25	21	50.0%
Missing	1	2.4%
Total	42	100%
Primary Language	N	%
English	39	92.9%
Other/Missing	3	7.1%
Total	42	100%
Race/Ethnicity	N	%
African American	11	26.2%
Latino	17	40.5%
Caucasian/white	21	50.0%
Multi-racial	12	28.6%
Other/Missing	6	14.4%
Total[1]	-	-
Mental Health Diagnosis[2]	N	%
Depressive Disorders	13	31.0%
Bipolar Disorders	5	11.9%
Anxiety/PTSD/Acute Stress Reaction	5	11.9%
Schizophrenia and Other Psychotic Disorders	16	38.1%
Other/Missing	3	7.1%
Total	42	100%

Characteristic	Total Participants (N=42)	
Sexual Orientation	N	%
Heterosexual or straight	37	88.1%
Another orientation/Missing	5	11.9%
Total	42	100%
Military Status	N	%
Never served in the military	40	95.2%
Missing	2	4.8%
Total	42	100%
Disability	N	%
Yes, Has a disability	5	11.9%
No, Does not have a disability	35	83.3%
Declined/Preferred not to answer	2	4.8%
Total	42	100%
Type of Disability	N	%
Learning Disability/Other	5	11.9%
Total[3]	-	-

[1] *Total may exceed 100% since youth could select more than one response.*
[2] *Mental health diagnosis information is obtain form BHS Cerner data system.*
[3] *Since participants could select more than one specific non-mental health related disability, the percentages may total more than the percent who indicated having any disability.*



THE CENTER FOR CHILD AND YOUTH PSYCHIATRY (CCYP) INNOVATIONS-22

Annual Report
Year 2 (7/01/2019-6/30/2020)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES (v.12.28.2020)

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO | UC San Diego

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Executive Summary

Program Overview

The County of San Diego Health and Human Services Agency (HHSA)'s Behavioral Health Services (BHS) Center for Child and Youth Psychiatry (CCYP) program is funded through the Innovations (INN) component of the Mental Health Services Act. The CCYP program was designed to provide psychiatric evaluation and treatment to children and youth who have completed behavioral health treatment yet require ongoing and complex medication monitoring that is not viable with their primary care physician (PCP). An additional unanticipated role has emerged, however, in which CCYP provides psychiatric care when other County-funded programs experience temporary gaps in ability to offer timely psychiatric care (e.g., primarily due to psychiatrist departures or leaves of absence). This role of providing services to "exception" referrals (i.e., youth who need psychiatric care, but are still receiving ongoing therapy elsewhere), ensured continuity of care and became part of standard CCYP operations during fiscal year (FY) 2019-20.

CCYP staff include care coordinators, a health care coordinator, and contracted psychiatrists who provide services both at centrally located clinics and remotely via telepsychiatry. CCYP is also expected to provide psychoeducation opportunities for the families of CCYP participants as well as for the broader San Diego community. The initial design of CCYP, which already included a substantial reliance upon telehealth services, allowed CCYP to adjust to the onset of the COVID-19 pandemic without substantial disruption to ongoing services.

Primary Findings for FY 2019-20

1. During FY 2019-20, a total of 397 youth were served by the CCYP program, including 211 new unduplicated clients and 186 prior year enrollees.
2. CCYP continued to support other BHS programs that experienced disruptions in their ability to provide psychiatric care services. During FY 2019-20 CCYP enrolled 32 youth from seven different agencies as exception referrals.
3. CCYP youth typically received services for an extended period of time as evidenced by a median duration of 354 days for the 248 persons who were receiving CCYP services as of 6/30/2020.

4. In quantitative and qualitative feedback, high percentages of both caregivers and youth indicated that they were satisfied with CCYP services.
5. BHS crisis/acute care services were rarely accessed during the 180 days prior to enrolling in CCYP or while enrolled in CCYP. This pattern, combined with the long average program durations indicate that CCYP was achieving the primary objective of maintaining stability for clients with complex medication management needs.

Additional Program Highlights

1. CCYP served a racially and ethnically diverse population with the majority of youth identifying as Hispanic or Latino (57.8%).
2. Program capacity issues contributed to staffing adjustments and the establishment of partnerships to help transfer more youth to primary care physicians for medication management.
3. Following the COVID-19 adjustments to service provision, CCYP psychiatrists and other staff indicated that they generally did not perceive a substantial difference between in-person and telehealth visits in regards to developing relationships with clients, the quality of communication, client focus during sessions, and client openness to sharing personal information.
4. CCYP psychiatrists and other staff estimated that between 11-25% of CCYP clients were unable to consistently participate in telehealth with video services due to issues such as not having access to a suitable device and/or reliable internet.

Conclusion

During FY 2019-20, the second year of program operations, CCYP enrolled 211 youth (179 authorized referrals and 32 exception referrals). Overall, the patterns of long CCYP program durations, relatively few program discharges, and similar frequency of BHS crisis and acute care services utilized while in CCYP as compared to immediately prior to enrolling in CCYP, indicated that CCYP generally achieved the core program objective of maintaining client stability through the provision of psychiatric services to youth who were anticipated to not need ongoing therapy. To help address issues with capacity and ongoing enrollment of new participants, CCYP initiated relationships with community partners that will help transition youth who have less complex medication needs back to PCPs or Federally Qualified Health Centers (FQHC) who are comfortable with managing psychotropic medications.

Primary Recommendations for FY 2020-21

1. Conduct a detailed review of CCYP staff roles, responsibilities, and workload to refine program capacity estimates for focal service populations.
2. Continue to develop community partnerships to facilitate transitioning stable clients with less complex medication requirement back to PCPs or FQHCs for medication management.
3. Continue to develop partnerships with other organizations that provide youth-oriented behavioral health services, but have insufficient or non-existent access to psychiatric medication management services.
4. Examine strategies to enhance client active engagement in services.

5. Revise evaluation approach to minimize staff and participant burden, while still generating information relevant to enhancing understanding of CCYP program outcomes and opportunities for improvement.

Program Description

CCYP was developed to provide medication support to select children and youth who have completed behavioral health treatment services yet require ongoing monitoring of complex psychotropic medications that are essential for the child or youth's wellness and stability, but not easily managed by their PCP. Services are provided through a variety of means, including a centrally located psychiatric clinic and telepsychiatry at satellite clinics and clients' homes. CCYP provides linkages and facilitates access to psychotropic medication, including the administration of long-acting injectable psychotropic medication, when indicated and necessary for the child or youth's stability. Additional goals of CCYP include improved communication and collaboration between CCYP, local referral partners (e.g., full-service clinics, schools, PCPs), and the communities they serve. CCYP is also expected to provide psychoeducation opportunities for the families of CCYP participants as well as for the broader San Diego community.

A San Diego-based community organization, New Alternatives, was contracted to provide CCYP services, which included: 1) establishing a team of psychiatrists, care coordinators, a nurse, and other program staff, 2) providing psychiatric evaluation and treatment, and 3) providing psychoeducation services to families.

During the first year of CCYP program operations (i.e., FY 2018-19), an unanticipated role for CCYP emerged. In addition to the intended focal population discussed above, CCYP was identified as an important county-wide resource that could fulfill the need for temporary access to psychiatric services when other county-funded programs experienced a gap in capability to offer timely psychiatric care (e.g., primarily due to psychiatrist departures or leaves of absence). Providing continuity of psychiatric care in these situations was determined to be an important ongoing benefit that CCYP could contribute to support the overall Children, Youth, and Families (CYF) BHS system of care. Youth who were admitted via this additional service strategy (i.e., exception referrals), typically differed from the traditional authorized CCYP enrollees in that they continued to receive psychotherapeutic care services from the referring agency while CCYP provided needed medication management support. This required additional communication and coordination between CCYP and the organization providing the therapy services. The CCYP program was originally expected to have a specific emphasis on providing psychiatric services to medically fragile children and youth who had complex ongoing psychotropic medication needs. Due to administrative and institutional barriers, the anticipated partnerships have not been viable so an emphasis on the medically fragile has not been implemented as part of CCYP operations.

Service Changes Due to COVID-19

The COVID-19 pandemic first affected the San Diego area in a substantial manner during March 2020. The County of San Diego issued a public health order effective 3/13/2020 to limit the size of public gatherings to less than 250 persons and to restrict access to hospitals and long-term care facilities serving seniors. This was followed by a statewide public health order on 3/19/2020 that required all non-essential workers to stay at home. During this time period, County BHS programs had to quickly adapt to the new

service delivery environment to protect both client and provider safety while continuing to provide mental health services. For many programs these changes included a switch to or greater utilization of telehealth services.

The initial design of CCYP, which included a substantial reliance upon telehealth services to provide psychiatric care throughout the entire county, allowed CCYP to adjust to the new practice realities without substantial disruption to ongoing services. The main change involved suspending the home visits by a CCYP care coordinator or nurse to facilitate the telehealth visits with clients (as was the practice prior to COVID-19). As of 6/30/2020 almost all service contacts provided by CCYP occurred via telehealth (i.e., phone or video). A more detailed discussion of CCYP experiences with providing telehealth services and the impact on CCYP staff and contracted psychiatrists is included in other sections of the report.

Participant Characteristics

As shown in Table 1, a total of 211 persons enrolled into the CCYP program during FY 2019-20 (as compared to 241 in FY 2018-19). Of the 211 enrollees, 179 (84.8%) were considered authorized enrollees who met the standard eligibility criteria (i.e., requiring medication management services, but not therapy services), and 32 (15.2%) were considered exception enrollees (a similar total number of exceptions and percentage of the CCYP population as in FY 2018-19, 34 and 14.1%, respectively). These exception enrollees were approved to receive CCYP services due to their inability to obtain needed psychiatric care at their primary (non-CCYP) service provider. A total of seven different organizations referred exception enrollees to CCYP during FY 2019-20.

Table 1. CCYP Program Enrollment for FY 2019-20 (N=211)

Type of CCYP Enrollee	N	% of Total
Authorized enrollees (i.e., not receiving therapy elsewhere)	179	84.8%
Exception enrollees (i.e., receiving therapy elsewhere)	32	15.2%
Total CCYP enrollees	211	100%

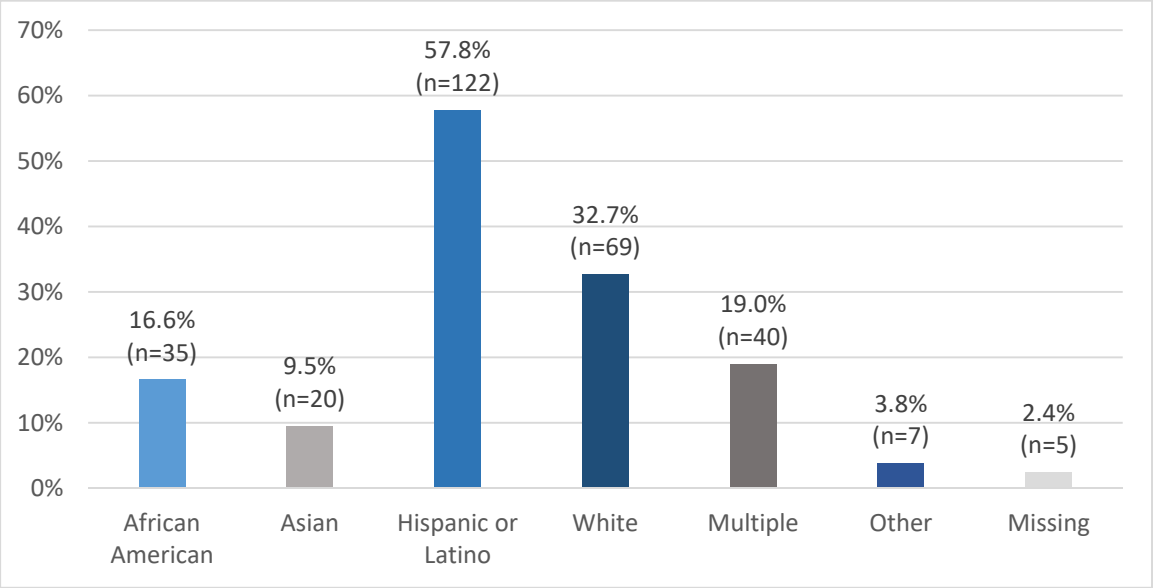
Key characteristics of the 211 persons who enrolled in CCYP during FY 2019-20 (i.e., includes both authorized and exception referrals) are discussed below. A more complete listing of participant characteristics and response options are listed in the appendix. Additional analyses not reported here found generally similar demographic characteristics between authorized and exception clients.

During FY 2019-20, the majority (67.3%; n=142) of clients enrolled in CCYP were at least 12 years old or older, with approximately one-third of clients age 5 to 11 (32.7%; n=69). Nearly equal numbers of males and females enrolled (49.8%; n=105 and 46.9%; n=99, respectively). Almost two-thirds of clients identified as heterosexual (63.5%; n=134), with 15.6% (n=33) indicating another orientation and 18.0% (n=38) declining to select an orientation.

While most clients reported English as their primary language (84.8%; n=179), over 10% indicated Spanish (11.4%; n=24) and 3.8% (n=8) another primary language. As shown in Figure 1, CCYP served a racially and ethnically diverse population. Over half of participants identified as Hispanic or Latino (57.8%; n=122),

followed by White (32.7%; n=69), multiple racial/ethnic backgrounds (19.0%; n=40), African American (16.6%; n=35), and Asian (9.5%; n=20).

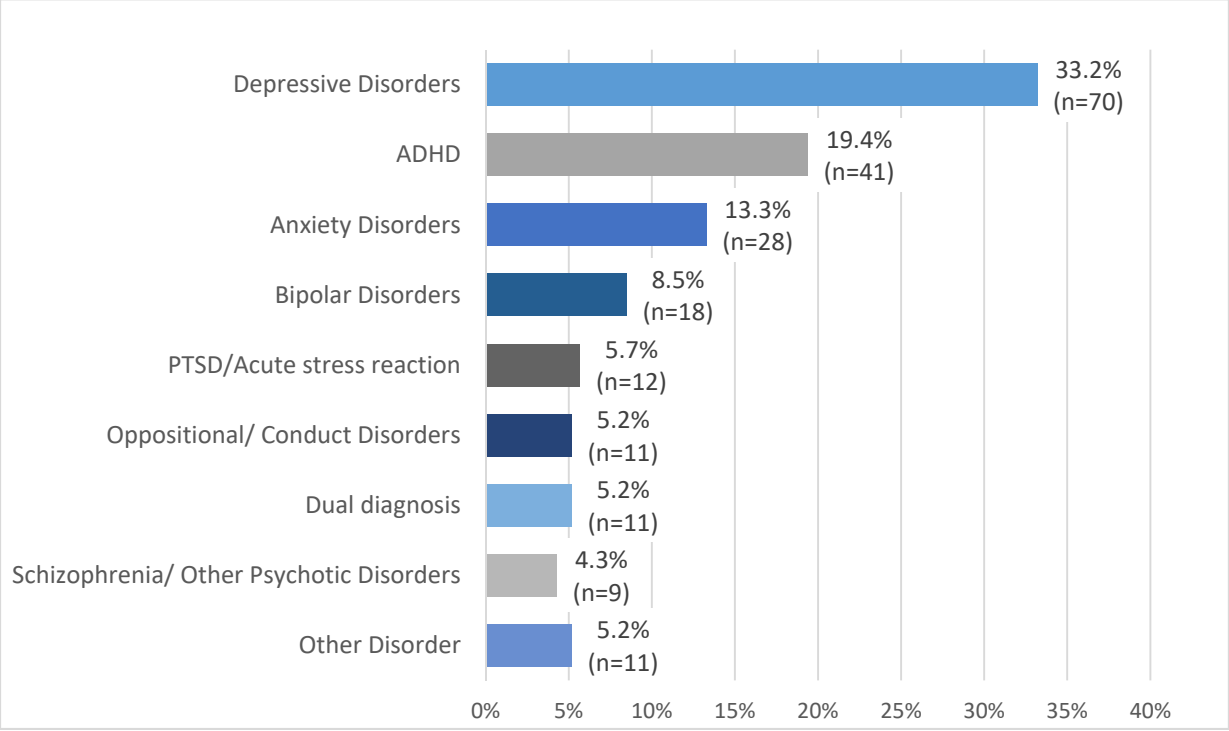
Figure 1. Race/Ethnicity of Clients Who Enrolled in CCYP during FY 2019-20 (N=211)



Note: Total may exceed 100% since more than one race/ethnicity could be selected.

As shown in Figure 2, the youth served by CCYP has a wide range of mental health diagnoses. The most common diagnoses included depression (33.2%; n=70), ADHD (19.4%; n=41), and anxiety disorder (13.3%; n=28).

Figure 2. Primary Mental Health Diagnosis of Youth Who Enrolled in CCYP during FY 2019-20 (N=211)



In addition, nearly one-third of the FY 2019-20 enrollees reported having a non-mental health related disability (31.3%; n=66). The most common disabilities among CCYP participants included learning disability (10.4%; n=22) followed by developmental disability (7.6%; n=16).

Utilization of Program Services

Program Service Contacts/Service Utilization

During FY 2019-20, the CCYP program served a total of 397 youth (345 authorized and 52 exception youth). This total was comprised of the 211 FY 2019-20 enrollees, discussed above, plus 186 prior year enrollees (166 authorized and 20 exception youth), who were still active during FY 2019-20. The 397 youth served during FY 2019-20 represented approximately 80% of the original service targets established prior to CCYP implementation (n=500). As discussed in more detail below, the lengthy duration of CCYP program participation likely contributed to fewer persons served per year than initially expected; however, developing a better understanding of program capacity is an objective that will be explored in more detail during FY 2020-21.

The following, more detailed analyses of CCYP program services focuses only on the experiences of the authorized youth who were active in CCYP during FY 2019-20 (n=345). As reported in Table 2, approximately 70% (n=239) of CCYP participants received at least one psychosocial assessment during FY 2019-20 (mean of 2.5). Almost all participants had at least one medication management-oriented service (88.7%; n=306), with an average of 5.4 services (note: the remaining persons without any CCYP medication services were active in CCYP for only a short period of time during FY 2019-20). Interactions with the nurse were also common with 71.9% having at least one session and a mean of 5.1 sessions. Overall, the CCYP program provided a substantial amount of psychiatric care to persons needing these specialized services.

Table 2. Services Provided by CCYP to Authorized Enrollees during FY 2019-20 (N=345)

Type of CCYP Service	Persons with at Least One Service		Mean Number of Services (of Persons with Service)	Total Number of Services
	N	%		
Any CCYP service	338	98.0%	12.4	4,203
Psychosocial assessment	239	69.3%	2.5	588
Medication management	306	88.7%	5.4	1,641
Nurse consult	248	71.9%	5.1	1,261
Other services (e.g., collateral)	249	72.2%	2.9	713

Program Duration and Discharge

To generate a better understanding of typical CCYP participation patterns, the following analyses examine CCYP program duration and discharge status for all authorized CCYP enrollees from both FY 2018-19 and FY 2019-20 (n=385). As of 6/30/2020, the majority (64.4%; n=248) were still enrolled in CCYP and only 35.6% (n=137) had discharged. Table 3 shows that the average duration for all persons still open in CCYP was 345.4 days. The median duration, which represents the midpoint value (i.e., 50% are shorter and 50% are longer), indicates that fully half of all CCYP authorized enrollees had been enrolled in CCYP for more

than 354 days). In contrast, those who had discharged by 6/30/2020 had shorter CCYP durations (i.e., mean and median of 204.4 and 172 days, respectively). These findings highlight that persons stay enrolled in CCYP for an extended period of time, with even those who had discharged typically participating in CCYP services for approximately six months. The lengthy CCYP program participation duration patterns likely contributed to the decrease in total new enrollment totals in FY 2019-20 (n=211) as compared to FY 2018-19 (n=241), since many of those persons enrolled in the prior year were still receiving CCYP services across years. As discussed in more detail below, efforts to increase program capacity contributed to the reorganization of some staffing responsibilities as well as provided additional motivation for developing partnerships to increase the number of youths who can be successfully discharged to PCPs or FQHCs for ongoing medication management.

Table 3. CCYP Duration for Total FY 2018-19 and FY 2019-20 Authorized Enrollees as of 6/30/2020 (N=385)

	N	Mean Number of Days	Median Number of Days
Open in CCYP as of 6/30/2020	248	345.4	354
Discharged as of 6/30/2020	137	204.4	172
Total enrollees	385	295.2	280

Table 4 presents the discharge reasons and CCYP durations for youth who had been discharged from the CCYP program as of 6/30/2020. Three reasons (noted in Table 4 in italics), accounted for 80.3% of all CCYP discharges: 1) required higher level of care (31.4%; n=43), 2) receiving services elsewhere (27.0%; n=37), and 3) lost contact (21.9%; n=30). Of note, since CCYP does not provide ongoing therapy, discharges due to needing "a higher level of care" typically involved situations where a determination was made that therapeutic care services were needed and then CCYP worked to facilitate continuity of care with a more traditional outpatient program. The median CCYP duration of 149 days for those who required a higher level of care indicated that these youth often received CCYP services for an extended period of time prior to exhibiting a need for further therapy services.

Table 4. CCYP Discharge Reason and Duration for Authorized Enrollees as of 6/30/2020 (N=385)

		% of All Discharges (n=137)	% of All Enrollees (n=385)	Duration in CCYP (days)	
Discharge Reason	**N**			**Mean**	**Median**
Required higher level of care	43	31.4%	11.2%	165.5	149.0
Receiving services elsewhere	37	27.0%	9.6%	200.8	161.0
Lost contact	30	21.9%	7.8%	250.0	223.0
No longer required services	9	6.6%	2.3%	268.8	230.0
Moved away from service area	8	5.8%	2.1%	146.1	156.0
Other	10	7.3%	2.6%	236.6	241.5
Total discharges as of 6/30/2020	**137**	**100.0%**	**35.6%**	**204.4**	**172.0**

In general, discharging any authorized CCYP enrollees was a relatively rare occurrence (i.e., only 35.6% of the 385 authorized children and youth enrolled during the past two years had been discharged as of 6/30/2020). Given that there were few discharges overall, a potentially more informative assessment of the prevalence of any specific discharge reason is the percentage of that reason out of all CCYP enrollees. From this perspective, the low prevalence of discharging persons to a higher level of care (i.e., 11.2% of the 385 CCYP authorized enrollees since FY 2018-19), combined with the high median CCYP duration of 149 days suggests a high degree of accuracy when making initial eligibility determinations regarding youth who are likely to be stable without needing ongoing psychotherapeutic treatment. Similarly, discharging a youth from CCYP specifically due to loss of contact was a relatively rare event (i.e., only 7.8% of all 385 enrollees), and often occurred after participating in CCYP services for more than 6 months (i.e., median duration of 223 days). This suggests that CCYP was generally successful at maintaining contact with their client population throughout the provision of medication management services.

Primary Program Outcomes

Three assessment-based outcome tools are reported in this section of the report. The Child and Adolescent Needs and Strengths (CANS) and the Pediatric Symptoms Checklist (PSC) are BHS-required tools to evaluate services provided across all levels and types of care. It is important to note that the primary goal of CCYP is one of maintaining stability through medication management only; thus, it is not necessarily expected that significant improvements would be seen between initial enrollment into CCYP and later follow-up assessments. Note, only clients that are part of the primary target population of "authorized" enrollees are included in these analyses (i.e., those who are only receiving CCYP medication management services and not receiving therapy services in other programs).

Child and Adolescent Needs and Strengths (CANS)

The CANS is a structured assessment used for identifying actionable needs and useful strengths among youth aged 6 to 21. It provides a framework for developing and communicating a shared vision by using assessment and interview information generated from both the youth and family members to inform planning, support decisions, and monitor outcomes. In CCYP, the CANS is completed by providers at initial intake, 6-month reassessment, and discharge. A total of 205 clients were open at least six months and had a follow-up or discharge CANS completed during FY 2019-20 to allow for an assessment of change.

The CANS assessment includes a variety of domains to identify the strengths and needs of each youth. Each domain contains a certain number of questions that are rated 0-3, with a "2" or "3" indicating a specific area that could potentially be addressed in the particular service or treatment plan (many of these areas are not specifically addressable by the medication management services provided by CCYP). Table 5 shows the mean number of needs at initial assessment and last available assessment for the domains of Child Behavioral and Emotional Needs, Life Functioning, and Risk Behaviors. These findings show statistically significant reductions at the last available follow-up for all three CANS domains. These ratings suggest that although only medication management services were provided by CCYP, there were still some areas of need identified at intake that had improved while participating in CCYP.

Table 5. CANS Average Change from Initial Assessment (N=205)

Key CANS Domains	Initial Mean Number of Needs	Follow-up Mean Number of Needs
Child Behavioral	2.28	1.44**
Life Functioning	1.27	1.01**
Risk Behaviors	0.24	0.15*

**statistical significance at p < 0.05; **statistical significance at p < 0.01*

An alternative approach to assess for CANS improvements is to identify the percent of persons who had a reduction of at least one need within a CANS domain (i.e., moving from a '2' or '3' at initial assessment to a '0' or '1' on the same item at the discharge assessment). As shown in Table 6, for each CANS domain approximately 55% of the children and youth served by CCYP experienced at least one reduction in a need item identified during the initial assessment. The percent of persons with an improvement across these three domains was slightly lower than what was reported in the FY 2018-19 Systemwide Annual Report for the overall County of San Diego Children, Youth, and Families system of care for discharged clients (i.e., approximately 70% had at least one improvement for each domain). This difference is likely due, in part, to the nature of the population served by CCYP, which is comprised of youth who are determined to no longer have needs for ongoing therapy. In this regard, the fact that the majority of the CCYP population exhibited at least some progress on the CANS suggests that CCYP services provided by the psychiatrists and care team continue to help children, youth, and families make improvements in their well-being.

Table 6. Persons with CANS Improvement at Follow-up (N=205)

Key CANS Domains	Persons with at Least One Need at Initial Assessment	Persons with any Item Improved to not be a Need at Follow-up	% of Persons with an Improvement at Follow-up
Child Behavioral	168	99	58.9%
Life Functioning	128	71	55.5%
Risk Behaviors	26	14	53.8%

Pediatric Symptoms Checklist (PSC)

The Pediatric Symptoms Checklist-35 (PSC-35) is a screening tool designed to support the identification of emotional and behavioral needs. Caregivers complete the PSC-Parent version on behalf of children and youth ages 3 to 18, and youth ages 11 to 18 complete the self-report PSC-Youth version. Clinical cutoff values indicating impairment for the total PSC score and the three subscales are located below in Table 7.

In FY 2019-20, the PSC-35 was administered at initial entry into CCYP, at 6-month reassessment, and discharge. However, as a voluntary self-report tool, the completion rate at follow-up or discharge was lower than clinician-completed tools such as the CANS. A total of 92 caregivers and 75 youth completed a PSC follow-up/discharge in FY 2019-20 as well as an initial PSC assessment to compare against. Table 7 shows that 58.3% of parents and 42.7% of youth reported total PSC scores at entry into CCYP that met or exceeded the PSC total score cut point for clinical concerns. Given that there are no therapy services provided as part of the CCYP program, it is not surprising that there was little change in the percentage

meeting the clinical threshold at follow-up for parent report (56.2%); however, the percent among youth reduced to 32.0%. Likewise, an examination of mean score changes shows a small, but statistically significant reduction (i.e., improvement) in total PSC score among youth. Among the PSC subscales, there was some indication of small improvements from initial Internalizing scores for both caregivers and youth, but not large enough to be statistically significant. With the reduced sample sizes for completed self-report PSC assessments, the findings should be interpreted cautiously as they may not reflect the broader experiences of the full CCYP population. Additional strategies are being implemented to increase the number of completed PSC assessments in future reporting periods. PSC scores will continue to be monitored in future years to see if significant differences in PSC change scores emerge.

Table 7. PSC Average Change from Baseline

	Parent/Caregiver Report (N=92)					Child/Youth Report (N=75)				
Higher score indicates worse condition		% Above clinical cutoff		Mean			% Above clinical cutoff		Mean	
Composites:	**N**	**Baseline %**	**Post %**	**Baseline**	**Post**	**N**	**Baseline %**	**Post %**	**Baseline**	**Post**
PSC Score	92	58.3%	56.2%	29.2	28.6^	75	42.7%	32.0%	24.1	22.1*
Attention Subscale	92	42.2%	33.3%	5.5	5.3	75	22.7%	17.3%	4.5	4.4
Internalizing Subscale	92	50.0%	38.2%	4.3	4.0^	75	40.0%	34.7%	3.8	3.3^
Externalizing Subscale	92	32.4%	34.0%	5.0	5.3	75	8.0%	10.7%	3.0	3.0

*^statistical significance at p < 0.10; *statistical significance at p < 0.05; [1] PSC Cutoff Scores: Total PSC Score ≥ 28, Attention Subscale ≥ 7, Internalizing Subscale ≥ 5, Externalizing Subscale ≥ 7*

To better understand the distribution of PSC change scores within the CCYP client population and to facilitate comparisons with the overall CYF BHS system, analyses were also conducted that examined the level of change from initial PSC assessment. Consistent with the FY 2018-19 Systemwide Annual Report, PSC change thresholds were operationally defined using the following five categories: increase in impairment (1+ point increase), no improvement (0-1 point reduction), small improvement (2-4 point reduction), medium improvement (5-8 point reduction), and a large improvement (9+ point reduction).

Table 8. Distribution of FY19-20 Change Scores from Initial PSC Assessment

	Parent/Caregiver Report (N=92)		Child/Youth Report (N=75)	
Amount of Change	**N**	**%**	**N**	**%**
Increased impairment (i.e., 1+ point increase)	35	38.0%	20	26.7%
No improvement (i.e., 0-1 point reduction)	18	19.6%	21	28.0%
Small improvement (i.e., 2-4 point reduction)	9	9.8%	10	13.3%
Medium improvement (i.e., 5-8 point reduction)	16	17.4%	8	10.7%
Large improvement (i.e., 9+ point reduction)	14	15.2%	16	21.3%

As shown in Table 8, approximately one third of parents/caregivers (32.6%) and children/youth (32.0%) in CCYP reported a medium or large improvement from their initial PSC assessment. Alternatively, 38.0% of caregivers and 26.7% of children reported a higher PSC score at follow-up, indicating some increased impairment. These findings suggest substantial variability among CCYP clients and their self-reported experiences of behavioral health changes. Substantial variability was also evident in PSC change score analyses within the overall CYF BHS system as reported in the FY 2018-19 Systemwide Annual Report. Approximately 55% of caregivers and children/youth reported medium or large improvements and about 25% reported increased impairment from initial PSC assessment. While caution is warranted when making any direct comparisons between CYF and CCYP PSC change score analyses, it is not surprising that the CCYP population appears to exhibit lower levels of PSC improvement given the specific nature of the CCYP population (i.e., demonstrating mental health stability without a perceived need for ongoing therapy) and the fact that the CYF analyses only include persons with completed discharge assessments, which likely includes a higher proportion of persons who have successfully concluded treatment goals. However, the variability of PSC change scores among CCYP clients is a reminder that there are CCYP clients who may benefit from additional therapeutic support and may require linkage to ongoing behavioral health care outside of CCYP.

PROMIS Global Health

The Patient-Reported Outcomes Measurement Information System (PROMIS) Global Health measure was administered at baseline, 6-month reassessment, and discharge to caregivers of youth ages 5 to 21 and youth (self-report; ages 8 to 21) to examine multiple health and quality-of-life-related domains. Items were rated on a five-point scale with higher scores indicating better health. To determine whether general health remained stable while enrolled in CCYP, PROMIS follow-up/discharge assessments were compared to initial PROMIS assessments completed upon intake into CCYP.

As shown in Table 9, during FY 2019-20, a total of 92 caregivers and 71 youth had assessments completed at baseline and at follow-up or discharge time points. In general, both caregivers and youth rated their quality of life and physical health higher at baseline than items related to their mental health. Stability across time points was seen for all items except, “how often does your child/do you feel really sad," which demonstrated a statistically significant change from initial assessment. This change, indicative of a reduction in feelings of sadness, was apparent in both the caregiver and youth responses. Additionally, both caregivers and youth indicated increased perception that caregivers listen to the ideas of the youth, suggesting some improvements in communication skills between youths and caregivers.

Table 9. Global Health Assessment Average Change from Baseline

	Parent/Caregiver Report (N=92)				Child/Youth Report (N=71)		
Global Health - Scale of 1 to 5 (higher numeric score indicates better outcome)	N	Baseline Mean	Follow-up Mean		N	Baseline Mean	Follow-up Mean
In general, would you say your child's health is:	92	3.7	3.6		71	3.6	3.6
In general, would you say your child's quality of life is:	92	3.7	3.6		71	3.6	3.7
In general, how would you rate your child's physical health:	92	3.7	3.6		71	3.5	3.6
In general, how would you rate your child's mental health, including mood and ability to think:	92	2.5	2.6		71	3.0	3.1
How often does your child feel really sad:	92	3.0	3.2*		71	3.2	3.5**
How often does your child have fun with friends:	92	3.1	3.3		71	3.7	3.7
How often does your child feel that you listen to his or her ideas:	92	3.3	3.6*		71	3.4	3.7*

**statistical significance at p < 0.05; **statistical significance at p < 0.01*

Caregiver and Client Perspectives on CCYP Services

A total of 120 caregiver feedback surveys and 97 youth feedback surveys were completed at either the 6-month time point or discharge during FY 2019-20. As shown in Table 10, a high percentage of both caregivers and youth indicated that they were satisfied with CCYP services (94.2% and 86.6%, respectively). In general, more caregivers than youth reported positive feedback regarding CCYP services and impact on client functioning and help-seeking. More caregivers reported that their child was able to function better in life (87.5%), compared to 79.4% of children/youth. Likewise, 92.5% of caregivers reported knowing where to get help and 86.7% felt comfortable seeking help, compared to 81.4% and 72.2%, respectively, of youth. The large majority of caregivers reported feeling the needs of their family were met by the program (90.1%), while 77.3% of youth reported the same.

Table 10. CCYP Services Feedback Survey

	% Agree/Strongly Agree	
Feedback Survey Item	**Caregivers (N=120)**	**Youth (N=97)**
As a result of this program, my child is/I am able to function better in daily life.	87.5%	79.4%
As a result of this program, my child/I know (s) where to get help for myself when I need it.	92.5%	81.4%
As a result of this program, my child is/I am more comfortable seeking help for myself.	86.7%	72.2%
My child's/my needs were met by this program.	90.1%	77.3%
Overall, I am satisfied with the services I received here.	94.2%	86.6%

For the open-ended caregiver and youth survey questions, at least two evaluators reviewed and coded the individual survey responses, and any discrepancies were discussed to arrive at a consensus on the key response themes. In terms of what CCYP was doing well for its clients, both caregivers and youth overall reported in open-ended responses that they felt supported by the program and found the medication management services that are the program's focus to be helpful. Caregivers particularly appreciated the flexibility and variability of appointments (e.g., increased accessibility via telepsychiatry visits) and some caregivers and youth reported positive client/family outcomes as a result of the program. When asked for any recommendations for CCYP program improvements, very few ideas were mentioned. Some caregivers indicated an interest for providing more counseling services as part of CCYP as opposed to getting transferred to another outpatient program if needs for therapy emerged. A few youth suggested expanding the services provided by CCYP to include access to therapy and some expressed interest in having more contact from the program. Overall, both the qualitative and quantitative feedback from caregivers and youth who completed a survey indicated high levels of satisfaction with CCYP services.

Behavioral Health Service (BHS) Utilization Patterns

Non-CCYP BHS Services Utilization 180 Days before CCYP Compared to 180 Days during CCYP

To assess the extent to which CCYP was able to support stable mental health among their clients without needs for crisis or acute care services, BHS service utilization patterns before and during CCYP enrollment were compared. This was accomplished by using the Cerner administrative database that documents the provision of BHS-funded services throughout San Diego County to identify mental health services received by CCYP clients from other BHS providers. Since the time enrolled in CCYP varies considerably and can be quite lengthy (i.e., mean number of days is 295.2), a method of standardizing service utilization during CCYP was needed to allow for an equivalent comparison to the BHS services received during the 180 days immediately prior to entering CCYP.

The standardized or average utilization of other BHS services during a 180 day period of time while enrolled in CCYP was calculated by adding up all FY 2019-20 BHS services (by service type) that occurred while clients were enrolled in CCYP and dividing that by the total number of days that all clients were

enrolled in CCYP during FY 2019-20. The resulting value represents the average number of BHS services that CCYP clients received per day, which is then multiplied by 180 to generate the estimate of BHS services that CCYP clients would receive during any 180-day time period in CCYP. This allows for an equivalent comparison to the average amount of BHS services utilized by youth during the 180 days prior to CCYP.

As shown in Table 11, for the 338 authorized youth served by CCYP during FY 2019-20 (note: seven youth out of the 345 authorized youth served by CCYP in FY 2019-20 were excluded from this analysis since they had multiple CCYP enrollments), crisis/acute care services such as inpatient hospitalizations, crisis stabilization visits, and PERT contacts were relatively rare events (i.e., substantially less than 1 instance on average), during the 180 days prior to CCYP enrollment. This is consistent with CCYP program design in that persons referred to CCYP have been determined to be relatively stable and thought to no longer need ongoing therapy. In comparison, during an equivalent 180 days while enrolled in CCYP services, the average number of instances for each of these crisis/acute care services was essentially the same as during the 180 days prior to entering CCYP. These findings provide evidence that CCYP was typically able to successfully maintain stable mental health among their participants. Given that CCYP was designed to provide psychiatric care without requiring participation in outpatient therapy, the average number of non-CCYP outpatient sessions understandably reduced substantially from 14.39 in the 180 days immediately before CCYP to 2.85 for 180 days enrolled in CCYP. Based on feedback from CCYP staff, many of the non-CCYP outpatient visits that occurred while enrolled in CCYP were related to situations where emergent circumstances resulted in the recognition that the youth now needed ongoing therapy. This often led to a "warm-handoff" period during which a person was simultaneously enrolled in both CCYP and another outpatient treatment program to facilitate a smooth transition.

Table 11. Comparison of BHS Service Utilization Prior to and During CCYP (N=338)

	Average number of BHS services per person during 180 days pre-CCYP	Average number of BHS services per person during standardized 180 days in CCYP
Inpatient hospitalizations	0.04	0.05
Crisis stabilization visits	0.14	0.18
PERT	0.04	0.05
Therapeutic behavioral services	2.43	0.31
Outpatient sessions (not CCYP)	14.39	2.85

Other Program Activities

Establishing New Partnerships

CCYP has been pursuing a partnership with Children's Primary Care Medical Group (CPCMG) to develop a transition pipeline from CCYP service utilization to primary care services with providers able to continue medication management. This desired transition was motivated, in part, by a recognition that CCYP had many long-term stable clients who would likely be able to be cared for by either their current PCP with proper supports or another PCP with more experience managing psychotropic mediations. Increasing the

number of youth who could successfully be cared for by PCPs would allow CCYP to admit additional new clients with more complex needs. In addition to the resources within CPCMG to assist PCPs with patients who have potentially complex behavioral health related medication management needs, other supports from SmartCare psychiatrists (an independent organization designed to provide psychotropic medication consultations for PCPs) can be accessed. In this manner, coordination and communication between CCYP, CPCMG, and SmartCare is anticipated to allow for more successful discharges of CCYP clients to the care of PCPs. In FY 2019-20, contact was made with CPCMG leadership/representatives and plans were developed to identify youth who were candidates for transitioning medication management services to a CPCMG PCP. This partnership will be further developed during FY 2020-21 as well as exploring opportunities to transition youth to local Federally Qualified Health Centers (FQHCs) for ongoing medication management needs.

Primary Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) CCYP stakeholder meetings and 2) the Annual CCYP Staff/Psychiatrist Survey. The stakeholder meetings were held throughout the year with representatives from BHS, CCYP, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual CCYP Staff/Psychiatrist Survey was conducted at the end of FY 2019-20. CCYP program staff and contracted psychiatrists were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. There were 10 respondents (5 psychiatrists and 5 care coordinators/administrators/support staff) from the 13 CCYP staff or contractors invited to participate in the survey (a 76.9% response rate). For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses and any discrepancies were discussed to arrive at a consensus on the key response themes.

Outreach/Recruitment

Overall, outreach and recruitment were not perceived as substantial challenges for the CCYP program during FY 2019-20. In its second year of operation, the CCYP program appeared to be well known throughout San Diego County and accepted referrals from 30 different organizations/providers (both authorized and exception referrals). In response to the substantial demands for youth psychiatric services, additional partnership opportunities were developed in which CCYP would be responsible for medication management while the partner organization continued to provide needed counseling/therapy services.

Engagement/Retention

The CCYP program was generally considered to be successful at retaining clients in services as evidenced by long program durations and few program drop-outs, however, CCYP staff acknowledged that active engagement in services by caregivers and/or youth was more of a concern. The engagement issues were evident via appointment no-shows and lack of client responsiveness. One explanation for these findings may be the shift this FY in care coordinator responsibilities from providing ongoing regular contact with families to primarily conducting intake and discharge assessments only (to allow the care coordinators to serve more clients). Ideas for improving caregiver and youth engagement included educating clients more thoroughly about expectations for their participation in CCYP services and increased communication with

clients about appointment reminders and follow-ups. Enhancing client engagement strategies was identified as a goal for FY 2020-21.

Experiences with Telehealth Services

CCYP was providing a mixture of in-person and telepsychiatry services prior to shifting exclusively to offering telehealth and telepsychiatry services with the onset of the COVID-19 pandemic during March of 2020. Both CCYP psychiatrists and other staff indicated that they generally did not perceive a substantial difference between in-person and telehealth visits that include a video in regards to developing relationships with clients, the quality of communication, client focus during sessions, and client openness to sharing personal information. Additionally, psychiatrists and other CCYP staff both indicated that they thought there was potentially greater engagement with clients via telehealth as well as a greater willingness to schedule sessions and a reduced number of "no-shows".

An examination of FY 2019-20 CCYP service utilization data from prior to the onset of COVID-19 pandemic (i.e., July 2019 – February 2020) confirmed this perception of CCYP staff, as face-to-face medication management sessions with the psychiatrist had a combined no-show/cancellation rate of approximately 15%, whereas the combined no-show/cancellation rate for telehealth sessions was approximately 5%. Of note, during the April-June 2020 time period, telehealth services maintained a combined no-show/cancellation rate of approximately 5%, but medication visits conducted via telephone (a very rare occurrence pre-pandemic), had a combined no-show/cancellation rate of approximately 10%.

CCYP psychiatrists and other staff estimated that between 11-25% of CCYP clients were unable to consistently participate in telehealth with video services due to issues such as not having access to a suitable device and/or reliable internet. CCYP psychiatrists highlighted the importance of having "back-up" plans (e.g., process for quickly restarting a session, switching to phone only), when video session disruptions occurred. Approximately 11-25% of clients were estimated to prefer telephone only sessions even when they had the ability to participate in a video session. This is likely due to both client preferences as well as the additional technology proficiency/comfort issues required to conduct a video session. Developing additional options for technology-oriented education and support was identified as a potential approach for increasing use of video sessions. Overall, psychiatrists and other CCYP staff strongly agreed that telehealth services should continue to be high priority for CCYP even after in-person visits become safe and available again.

Impact of COVID-19 on Program Staff

Overall, CCYP psychiatrists and other staff members indicated there were aspects of their lives, both related and unrelated to work, which changed substantially due to the COVID-19 pandemic and contributed to additional stress and anxiety. Some CCYP personnel also indicated noticing increased stress and potential for destabilization among CCYP youth and their caregivers.

Workload Challenges

Factors identified by CCYP staff that inhibit achievement of CCYP objectives included the high caseload levels for the Care Coordinators (i.e., often 60 or more), that make it difficult to provide follow-up services

as frequently and as comprehensively as initially planned. As noted above, the Care Coordinator role was reconfigured during FY 2019-20 to primarily focus on client intake assessments and the facilitation of more psychiatry sessions. Some families have more extensive needs that may benefit from additional Care Coordinator services. In particular, the exception referrals who are still receiving psychotherapeutic services elsewhere do not have the benefit of the natural within-agency lines of communication across psychiatry and psychotherapy, thus requiring additional support from CCYP Care Coordinators. Addressing such needs while still maintaining a large caseload represented a challenge for Care Coordinators. Efforts to further improve work efficiencies and effectiveness will continue in FY 2020-21.

Program Changes from Initial Design

In addition to changes brought about by the response to COVID-19 during the final few months of FY 2019-20 (i.e., transitioning exclusively to telehealth service provision), CCYP also adjusted the workflow for the Care Coordinators earlier in FY 2019-20. Due to high client caseloads for the Care Coordinators (typically 60 or more when fully staffed, higher when not), and the need to increase overall program capacity by facilitating additional psychiatry visits, the role of the Care Coordinators shifted such that monthly follow-up with clients were no longer feasible. Care Coordinators continued to provide additional support and resources as needed when informed of issues by psychiatrists and/or family. As discussed above, due to administrative and institutional barriers the anticipated partnerships that would have allowed CCYP to have an emphasis on serving medically fragile youth have not been viable so that part of the initial CCYP design has not been implemented.

Program Recommendations

1. Conduct a detailed review of CCYP staff roles, responsibilities, and workload to refine program capacity estimates for focal service populations.
2. Continue to develop community partnerships to facilitate transitioning stable clients with less complex medication requirements back to PCPs or FQHCs for medication management.
3. Continue to develop partnerships with other organizations that provide youth-oriented behavioral health services, but have insufficient or non-existent access to psychiatric medication management services.
4. Examine strategies to enhance client active engagement in services.
5. Revise evaluation approach to minimize staff and participant burden, while still generating information relevant to enhancing understanding of CCYP program outcomes and opportunities for improvement.

Conclusion

During FY 2019-20, the second year of program operations, CCYP served a total of 397 children and youth. Of these, 211 enrolled in CCYP during FY 2019-20 (179 authorized referrals and 32 exception referrals), whereas the remainder had enrolled in the prior year. The slight decrease in enrollment from the prior year (n=241), was likely due to the extended duration of CCYP program participation (i.e., mean of 295.2 days), such that many of the persons enrolled in the prior year were still active in CCYP during FY 2019-20 and created capacity challenges for the CCYP program during FY 2019-20. Overall, the patterns of long

CCYP program durations, relatively few program discharges, and similar amounts of BHS crisis and acute care services utilized while in CCYP as compared to immediately prior CCYP, indicated that CCYP generally achieved the core program objective of maintaining client stability through the provision of psychiatric services to youth who were anticipated to not need ongoing therapy. Findings from the outcome assessments (i.e., CANS and PSC), suggest that even without an explicit treatment focus, there were often improvements in behavior or functioning from the perspective of CCYP providers and/or caregivers and youth.

To help address issues with capacity and ongoing enrollment of new participants, CCYP, with the assistance of the evaluation team, initiated a partnership with CPCMG during FY 2019-20 to transition youth with less complex medication needs to PCPs or FQHCs who are comfortable with managing psychotropic medications. As needed, SmartCare services (an independent county-funded program that provides medication consultation services by psychiatrists) will be utilized to provide PCPs with additional supports. This partnership will continue to be developed during FY 2020-21. Now that the program has a more thorough understanding of the service needs of the focal population, CCYP will also conduct a detailed review of staffing roles, responsibilities, and workload during FY 2020-21 to refine program capacity estimates and optimal team structure.

For more information about this Innovation program and/or the report please contact:
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Appendix

Characteristics of Participants who Enrolled during FY 2019-20

Characteristic	Total Participants (N=211)	
Age Group	N	%
5 to 11	69	32.7%
12 to 15	71	33.6%
16 to 17	55	26.1%
18 to 20	16	7.6%
Total	211	100%
Gender	N	%
Male	105	49.8%
Female	99	46.9%
Another gender identity	6	2.8%
Prefer not to answer	1	0.5%
Total	211	100%
Sexual Orientation	N	%
Heterosexual or straight	134	63.5%
Gay or lesbian	8	3.8%
Bisexual/Pansexual/Sexually fluid	20	9.5%
Other sexual orientation	5	2.4%
Prefer Not to Answer	38	18.0%
Missing	6	2.8%
Total	211	100%
Language	N	%
English	179	84.8%
Spanish	24	11.4%
Other	8	3.8%
Total	211	100%

Characteristic	Total Participants (N=211)	
Race/Ethnicity	N	%
African American	35	16.6%
Asian	20	9.5%
Hispanic or Latino	122	57.8%
White	69	32.7%
Multiple	40	19.0%
Other	8	3.8%
Missing	5	2.4%
Total[1]	-	-
Mental Health Diagnosis[2]	N	%
Depressive Disorders	70	33.2%
ADHD	41	19.4%
Anxiety Disorders	28	13.3%
Bipolar Disorders	18	8.5%
PTSD/Acute stress reaction	12	5.7%
Oppositional/ Conduct Disorders	11	5.2%
Dual diagnosis	11	5.2%
Schizophrenia/ Other Psychotic Disorders	9	4.3%
Other Disorder	11	5.2%
Total	211	100%
Disability	N	%
Yes, has a disability	66	31.3%
No, does not have a disability	135	64.0%
Declined/Preferred not to answer	10	4.7%
Total	211	100%

Characteristic	Total Participants (N=211)	
Type of Disability	N	%
Seeing	13	6.2%
Hearing	7	3.3%
Other Communication	8	3.8%
Learning	22	10.4%
Develop	16	7.6%
Other Mental	5	2.4%
Physical	5	2.4%
Other	28	12.2%
Total[3]	-	-

[1] Total may exceed 100% since participants could select more than one response.
[2] Mental health diagnosis information is obtained from BHS Cerner data system.
[3] Since participants could select more than one specific non-mental health related disability, the percentages may total more than the percent who indicated having any disability.

APPENDIX O

GLOSSARY OF ACRONYMS

Glossary of Acronyms

ACE – Alliance for Community Empowerment
ACL – Access and Crisis Line
ACT – Assertive Community Treatment
ASP – Augmented Services Program
ASO – Administrative Services Organization
API – Asian/Pacific Islander
AOA – Adults and Older Adults
B&C – Board & Care
BHAB – Behavioral Health Advisory Board
BHETA – Behavioral Health Training Academy
BHS – County of San Diego Health and Human Services Agency, Behavioral Health Services
BPSR – Bio Psycho Social Rehabilitation
CalMHSA – California Mental Health Services Authority
CalWORKs – California Work Opportunity and Responsibility to Kids
CASRC – Child and Adolescent Research Center
CCBH – Cerner Community Behavioral Health
CCRT – Cultural Competency Resource Team
CFTN – Capital Facilities and Technological Needs
CHFFA – California Health Facility Financing Authority
CHW – Community Health Workers
CWS – Child Welfare Services
CLAS – Culturally and Linguistically Appropriate Services
CREST – Cognitive Rehabilitative and Exposure Sorting Therapy
CSEC - Commercially Sexually Exploited Children
CPP – Community Planning Process
CSU – Crisis Stabilization Unit
CSS – Community Services and Supports
CYF – Children, Youth, and Families
DMC/ODS – Drug Medi-Cal Organized Delivery System
EMASS – Elder Multicultural Access and Support Services
ESU – Emergency Screening Unit
FSP – Full Service Partnership
FY – Fiscal Year
HHSA – Health and Human Services Agency
HCDS – Housing and Community Development Services
HOW – Homeless Outreach Workers
HSRC – Health Services Research Center
ICM – Institutional Case Management
IHOT – In-Home Outreach Team
ILA – Independent Living Association
IMAR – Illness Management Recovery

INN – Innovation
LGBTQ – Lesbian, Gay, Bisexual, Transsexual, Questioning
MDT – Multidisciplinary Team
MHFA – Mental Health First Aid
MHSA – Mental Health Services Act
MHSOAC – Mental Health Services Oversight and Accountability Commission
MIS – Management Information System
MORS – Milestones of Recovery
NAMI – National Alliance on Mental Illness
NPLH – No Place Like Home
OE – Outreach and Engagement
PEARLS – Program to Encourage Active and Rewarding Lives
PERT – Psychiatric Emergency Response Team
PEI – Prevention and Early Intervention
PIT – Performance Enhancement Team
PSC – Peer Specialist Coaches
POFA – Project One for All
QI – Quality Improvement
REACH – Resources for Enhancing Alzheimer's Caregiver Health
RER – Revenue and Expenditure Report
ReST – Recuperative Services Treatment
ROAM – Roaming Outpatient Access Mobile Services
RMQ – Recovery Markers Questionnaire
SATS-R – Substance Abuse Treatment Scale, Revised
SBCM – Strengths-Based Case Management
SBIRT – Screening, Brief Intervention and Referral to Treatment
SD – System Development
SDCPH – San Diego County Psychiatric Hospital
SDHC – San Diego Housing Commission
SED – Serious Emotional Disturbance
SIPS – Structured Interview for Prodromal Symptoms
SMI – Serious Mental Illness
SSI – Supplemental Security Income
START – Short-Term Acute Residential Treatment
SUD – Substance Use Disorder
TAOA – Transition Age Youth, Adults and Older Adults
TAY – Transition Age Youth
TN – Technological Needs
UCSD – University of California, San Diego
WET – Workforce Education and Training
WIC – California Welfare and Institutions Code
WRAP – Wellness Recovery Action Plan

APPENDIX P

GLOSSARY OF TERMS

Glossary of Terms

Aftercare: is a program of outpatient treatment and support services provided for individuals discharged from an institution, such as a hospital or mental health facility, to help maintain improvement, prevent relapse, and aid adjustment of the individual to the community. Aftercare may also refer to inpatient services provided for convalescent patients, such as those who are recovering from surgery.

Assertive Community Treatment (ACT): is a team-based treatment model that provides multidisciplinary, flexible treatment and support to people with mental illness 24/7. ACT is based around the idea that people receive better care when their mental health care providers work together. ACT team members help the person address every aspect of their life, whether it is medication, therapy, social support, employment or housing.

Case Management: is a range of services provided to assist and support individuals in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational, and other services essential to meeting basic human services.

Cognitive Training: is a term that reflects the theory that cognitive abilities can be maintained or improved by exercising the brain, in an analogy to the way physical fitness is improved by exercising the body.

Complex Behavioral Health Conditions: can include serious mental illness (e.g., schizophrenia, bipolar disorder, or major depressive disorder) or other mental health conditions, with or without co-occurring substance use disorders that, individually or in combination, have an impact on one or more functional abilities. Functional limitations can impede an individual's ability to live independently at home and engage in the community.

Crisis Intervention: is the brief 'first-aid' use of psychotherapy or counseling to persons who have undergone a highly disruptive experience, such as an unexpected bereavement or a disaster. Crisis intervention may prevent more serious consequences of the experience, such as posttraumatic stress disorder. It is also a psychological intervention provided on a short-term, emergency basis for individuals experiencing mental health crises, such as an acute psychotic episode or attempted suicide.

Culturally Appropriate: community interventions that are defined as meeting each of the following characteristics: (a) The intervention is based on the cultural values of the group, (b) the strategies that make up the intervention reflect the subjective culture (attitudes, expectancies, norms) of the group, and (c) the components that make up the strategies reflect the behavioral preferences and expectations of the group's members.

Exposure Therapy: is a form of therapy in which clinicians create a safe environment in which to "expose" individuals to the things they fear and avoid. The exposure to the feared objects, activities or situations in a safe environment helps reduce fear and decrease avoidance.

Family Engagement: is a family-centered and strengths-based approach to making decisions, setting goals, and achieving desired outcomes for children and families. It encourages and empowers families to be their own champions, working toward goals that they have helped to develop based on their specific family strengths, resources, and needs.

Family Groups: is a therapeutic method that treats a family as a system rather than concentrating on individual family members. The various approaches may be psychodynamic, behavioral, systemic, or structural, but all regard the interpersonal dynamics within the family as more important than individual intrapsychic factors.

Full Service Partnership (FSP): is a collaborative relationship between the County of San Diego and the client, and when appropriate the client's family, through which the client may access a full spectrum of community services to achieve identified goals.

Hoarding: is a compulsion that involves the persistent collection of useless or trivial items (e.g., old newspapers, garbage, magazines) and an inability to organize or discard these. The accumulation of items (usually in piles) leads to the obstruction of living space, causing distress or impairing function. Any attempt or encouragement by others to discard hoards causes extreme anxiety.

Interoperability: means the ability of health information systems to work together within and across organizational boundaries in order to advance the effective delivery of healthcare for individuals and communities.

Milestones of Recovery Scale (MORS): is an evaluation tool for tracking the process of recovery for individuals with mental illness. MORS is rooted in the principles of psychiatric rehabilitation and defines recovery as a process beyond symptom reduction, client compliance and service utilization. It operates from a perspective that meaningful roles and relationships are the driving forces behind achieving recovery and leading a fuller life.

Motivational Interviewing: is a client-centered yet directive approach for facilitating change by helping people to resolve ambivalence and find intrinsic reasons for making needed behavior change. Originally designed for people with substance use disorders, motivational interviewing is now broadly applied in health care, psychotherapy, correctional, and counseling settings. It is particularly applicable when low intrinsic motivation for change is an obstacle. Rather than advocating for and suggesting methods for change, this approach seeks to elicit the client's own goals, values, and motivation for change and to negotiate appropriate methods for achieving it.

Neuropsychological Testing: is an evaluation of the presence, nature, and extent of brain damage or dysfunction derived from the results of various neuropsychological tests. It includes any of various clinical instruments for assessing cognitive impairment, including those measuring memory, language, learning, attention, and visuospatial functioning.

Outreach: an activity of providing services to any populations who might not otherwise have access to those services. In addition to delivering services, outreach has an educational role, raising the awareness of existing services

Peer Support: includes counseling or support by an individual who has experience and/or status equal to that of the client.

Personal Health Record (PHR): is an electronic application through which individuals can access, manage and share their health information, and that of others for whom they are authorized, in a private, secure, and confidential environment. A PHR includes health information managed by the individual. The clinician's record of patient encounter, a paper- chart or electronic medical record (EHR) is managed by the clinician and/or health care institution.

Primary Care: is the basic or general health care a patient receives when he or she first seeks assistance from a health care system. General practitioners, family practitioners, internists, obstetricians, gynecologists, and pediatricians are known as primary care providers.

Psychiatric Assessments: are evaluations based on present problems and symptoms, of an individual's biological, mental, and social functioning, which may or may not result in a diagnosis of a mental illness.

Screening, Brief Intervention and Referral to Treatment (SBIRT) Model: is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use.

Serious Emotional Disturbance (SED): is a condition that affects persons from birth up to age 18 who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual (DSM) that results in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Serious Mental Illness (SMI): is a condition that affects persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the DSM that has resulted in serious functional impairment,

which substantially interferes with or limits one or more major life activities such as maintaining interpersonal relationships, activities of daily living, self-care, employment, and recreation.

Stigma: includes prejudicial attitudes and discriminating behavior directed towards individuals with mental health problems or the internalizing by the mental health sufferer of their perception of discrimination.

Strengths Based Approach: is a specific method of working with and resolving problems experienced by the presenting person. It does not attempt to ignore the problems and difficulties. Rather, it attempts to identify the positive basis of the person's resources (or what may need to be added) and strengths that will lay the basis to address the challenges resulting from the problems.

Substance Use Disorder (SUD): is recurrent use of alcohol and/or drugs causing clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

Suicide Prevention: is an umbrella term used for the collective efforts of local community-based organizations, health professionals and related professionals to reduce the incidence of suicide; reduce factors that increase the risk for suicidal thoughts and behaviors; and increase the factors that help strengthen, support, and protect individuals from suicide.

Supplemental Security Income benefits (SSI): pays benefits to disabled adults and children who have limited income and resources. SSI benefits also are payable to people 65 and older without disabilities who meet the financial limits. SSI is a Federal income supplement program funded by general taxes. It is designed to help aged, blind, and disabled people, who have little or no income and provides cash to meet basic needs for food, clothing, and shelter.

Supportive Housing: is an evidence-based housing intervention that combines non-time-limited affordable housing assistance with wrap-around supportive services for people experiencing homelessness, as well as other people with disabilities.

Trauma Informed Care: is a style of care that accounts for the widespread impact of trauma and the understanding of potential paths for recovery. It includes the recognition of the signs and symptoms of trauma in clients, families, staff, and others. Organizations that are trauma-informed fully integrate knowledge about trauma into policies, procedures, and practices and actively avoid re-traumatization.

Warning Signs of Suicide: include behaviors (examples listed below) that may be signs that someone is thinking about suicide.

- Talking about wanting to die or to kill oneself.

- Looking for a way to kill oneself, such as searching online or buying a gun.
- Talking about feeling hopeless or having no reason to live. Talking about feeling trapped or unbearable pain.
- Talking about being a burden to others.
- Increasing the use of alcohol or drugs.
- Acting anxious or agitated; behaving recklessly.
- Sleeping too little or too much.
- Withdrawing or feeling isolated.
- Showing rage or talking about seeking revenge.
- Displaying extreme mood swings.

APPENDIX Q

STAKEHOLDER COMMENTS

MHSA Fiscal Year 2021-22 Annual Update

30-Day Public Notice Feedback Summary

Summary	Response
A comment was received via the MHSA Annual Update electronic survey that described the situation of persons who are homeless in the central neighborhoods of San Diego. The comment questions the value of service interventions that may be refused by the individuals. The comment mentions health conditions in encampments.	Noted.
A comment was received via the MHSA Annual Update electronic survey that mentions multiple issues addressing the following concerns. • Amount of paperwork required of clinicians, including those in multiple locations. • The number of County staff providing oversight. • Use of Psychiatric Nurse Practitioners in Children's services. • Bottlenecks and wait times for treatment following referrals. • Retention issues for clinicians, citing salary range, paperwork burden, and workforce development. • Staffing ratios for in-patient pediatric psychiatry.	Noted.
A comment was received via the MHSA mailbox from a parent of youth with mental health issues that outlines the value of youth peer-to-peer programs, including online venues, as an effective intervention with the ability to connect with diverse audiences. The comment also advocates for expanded K-12 mental health and whole health education in schools.	Noted.
A comment was received during the Behavioral Health Advisory Board Public Hearing that questioned the timing of public input each year for the MHSA Program and Expenditure Plan.	Noted.