County of San Diego
MHSA Three-Year Program and Expenditure Plan: Fiscal Years 2017-18 through 2019-20

August 3, 2017

Health and Human Services Agency

This report provides the County of San Diego Health and Human Services Agency's Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan for Fiscal Years 2017-18 through 2019-20 (MHSA Three-Year Plan). This report conforms to applicable regulations in the California Code of Regulations (3200.000-3320) and Welfare and Institutions Code (5800-5891).

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

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Director, Behavioral Health Services

A LETTER FROM THE BEHAVIORAL HEALTH DIRECTOR

How do we tell our story? Liken us to an orchestra, where many parts must work together coherently. We always remember our central mission, providing mental health and substance use disorder services for children, youth, families, adults, and older adults. Meeting this mission successfully takes an enormous amount of engaged teamwork. Always at top of our desks are three blueprints: *Live Well San Diego*, the Behavioral Health Services (BHS) Ten Year Roadmap, and the Mental Health Services Act (MHSA). This MHSA Three-Year Program and Expenditure Plan shows how performance measures and community stakeholder input guide our path as we implement these blueprints for coordinated care for behavioral health needs in San Diego County.

At the core of our story is *Live Well San Diego*, the County of San Diego's vision for healthy, safe, and thriving communities. This vision aims to create a culture of wellness, which we see demonstrated in all the MHSA program components across our systems of care. Coordinated care means a whole-person, patient-centered approach for co-occurring substance use disorders, mental health, and physical needs. Programs work across boundaries engaging all health and human service providers. A culture of wellness is based on a trauma-informed workforce and a clear understanding of a community's needs and engaged participation.

In 2016, we introduced our Ten Year Roadmap, charting the vision of our system of care. The MHSA remains at the heart of our advancement to a seamless and integrated system. Since 2008, we have expanded MHSA programs and have maximized the investment for many of its fundamental components.

Also in 2016, the County of San Diego Board of Supervisors approved Project One for All (POFA), a new initiative combining services with housing resources to help homeless individuals with serious mental illness. Expanded programs also include supportive services and beds for individuals who are homeless, and programs for youth involved in the justice system.

Our story is not complete without acknowledging our community partners, more than 200 organizations and individuals who provide and/or receive services that advance the *Live Well San Diego* vision by encouraging healthy lifestyle choices for children and adults, reducing stigma so that those with mental illness or challenges with substance use disorders have equal opportunities, and informing the public about recovery principles and successful outcomes. Further details for all MHSA-connected programs and initiatives are described within this MHSA Three-Year Plan.

Live Well,

ALFREDO AGUIRRE, LCSW, Director
HHSA Behavioral Health Services, County of San Diego

EXECUTIVE SUMMARY

BACKGROUND

Proposition 63, also known as the Mental Health Services Act (MHSA), was passed by voters in November 2004 and became a state law on January 1, 2005. The MHSA imposes a 1% income tax on personal annual income in excess of $1 million. The MHSA provides funding to counties to address a broad continuum of prevention, early intervention, and service needs, and the necessary infrastructure, technology, and training elements that will effectively support the public mental health system. It also provides funds for innovative mental health programs.

The vision behind the MHSA is to build a system in which access is easier, services are more 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. As the MHSA-funded portion of the system of care approaches build-out after ten years of growth and community involvement, we turn our attention to identifying and improving processes and focusing on the most effective approaches.

COMMUNITY PLANNING PROCESS

From September through November 2016, BHS conducted a dynamic Community Planning Process (CPP) to gather input from various community partners and stakeholders to inform the development of the MHSA Three-Year Plan. More than 550 people participated in 12 community forums and more than 100 individuals joined in 6 specialty focus groups to provide input and feedback. Decisions on new or expanded services and programs were made at the local level with significant stakeholder input. The CPP provides stakeholders and the County with an opportunity to collaborate and determine where to most effectively focus resources in order to meet the needs of County residents.

INVESTMENT OF RESOURCES

The MHSA Three-Year Program and Expenditure Plan for Fiscal Years 2017-18 through 2019-20 provides information on programs and expenditures for Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), Workforce Education and Training (WET), and Capital Facilities and Technological Needs (CFTN) components. The MHSA Three-Year Plan also provides details of the CPP, future funding priorities, and descriptions of new INN programs. By the end of FY 2017-18, it is estimated that the County will have invested over $1 billion in MHSA programs.

The proposed MHSA spending plan in FY 2017-18 is $197.5 million, reflecting over a $15 million increase from the previous fiscal year budget of $182.2 million. The proposed MHSA spending plans for FY 2018-19 and 2019-20 reflect decreases due to the one-time CFTN funds being fully expended by the June 30, 2018 deadline. The following is the planned total expenditures for all MHSA components in Fiscal Years 2017-18 through 2019-20:

Fiscal Year	Estimated Total MHSA Budget
2017-18	$197,523,661
2018-19	$187,769,099
2019-20	$184,142,635

A summary of the proposed expenditures by MHSA component for the three fiscal years is available in Appendix A.

SUMMARY OF ENHANCEMENTS AND NEW PROGRAMS

Below is a listing of MHSA programs that are enhanced or new in FY 2017-18:

COMMUNITY SERVICES AND SUPPORTS (CSS)

The FY 2017-18 enhancements and new programs below reflect a total increase of $12,375,894 in proposed CSS funding from the previous fiscal year.

ENHANCEMENTS:

- Ten additional **Psychiatric Emergency Response Teams (PERT)** will be added, for a total 50 PERT teams in FY 2017-18, to improve crisis response in various regions of San Diego County.
- The **Adult Full Service Partnership (FSP) Assertive Community Treatment (ACT)** programs in East and South Regions will be enhanced to provide additional treatment slots for persons with SMI, to reduce homelessness. This enhancement supports Project One for All (POFA).
- Two **Probation Officers to Support Adult Full-Service Partnership (FSP)** programs will be added to FSP programs to further strengthen the collaboration with Public Safety in ensuring justice involved persons with SMI who are experiencing homelessness receive the appropriate mental health services.
- Various **Children's Full Service Partnership (FSP)** programs throughout San Diego County will be enhanced to ensure a comprehensive array of services which may include case management, family or youth partner support and/or alcohol and drug counselors.
- The **Children's Emergency Screening Unit (ESU)** program will expand the capacity of emergency crisis stabilization services for children and youth from 4 to 12 beds and relocate to a centralized location in the County of San Diego.
- The **Short-Term Acute Residential Treatment (START)** programs will be enhanced by providing 24 hour nursing staff at various locations throughout San Diego County to ensure sufficient medical support for physical health issues and add an aftercare specialist to ensure a "warm handoff" to community services once a client has been discharged.
- **Supplemental Security Income (SSI) Advocacy Services for Children** will be enhanced to continue the education and support to families of children who could benefit from SSI to successfully complete the application process.
- The **Institutional Case Management (ICM)** program for older adults will be enhanced to serve additional clients who suffer from severe mental illness and are in a locked setting to support reintegration into the community.
- The two **North County Crisis Stabilization Services programs** will be fully funded to improve the access to crisis stabilization services for the residents of North County.

NEW PROGRAMS:

- The adult **Full Service Partnership (FSP) Assertive Community Treatment (ACT) Justice Integrated Services** program will add new FSP ACT treatment slots for justice involved persons with SMI and co-occurring disorders, to ensure their integration back into the community and decrease future justice system involvement. This program supports Project One for All (POFA).
- The adult **Full Service Partnership (FSP) Assertive Community Treatment (ACT) Transitional Residential and Adult Residential** program will provide psychosocial rehabilitative services for residents with SMI who would benefit from unlocked transitional residential rehabilitative services.

- The **Tenant Peer Support Services Outpatient Clinic Hub** program will provide housing support for homeless clients to link and sustain housing. This program supports Project One for All (POFA).
- **Adult Full Service Partnership (FSP) Assertive Community Treatment (ACT)** programs in Central/ North Central and North Regions will provide additional treatment slots for persons with SMI to reduce homelessness. This enhancement supports Project One for All (POFA).
- The **Adult FSP ACT** program in Central/North Central, in partnership with the San Diego Housing Commission, will provide housing subsidies and supports for 100 homeless clients with SMI and co-occurring disorders to link them to and sustain housing in their recovery.
- A **Pilot Program with the Courts in Central and South Region** will add three Behavioral Health Assessors to screen, assess, and provide linkage for individuals being discharged from jail into behavioral health treatment and services in the community.
- A **Pilot Program to Co-Locate Mental Health Staff at the Lemon Grove Family Resource Center** will add three Behavioral Health Assessors to screen, assess, and provide linkage for individuals being discharged from jail into behavioral health treatment and services in the community.
- The **Our Safe Place** program will provide a full range of mental health treatment services for Lesbian, Gay, Bisexual, Transgendered, and Questioning (LGBTQ) youth including support groups for youth, family members and/or caregivers, youth partners, and alumni mentorship programs.
- The **I-CARE** program for **Commercially Sexually Exploited Children (CSEC)** will provide a full range of therapeutic services, as well as survivor advocacy, drop-in centers, and alumni mentorship programs for youth who have been or are at-risk of commercial sexual exploitation.

PREVENTION AND EARLY INTERVENTION (PEI)

In FY 2017-18, PEI programs were not enhanced due to component funding being maximized in previous fiscal years. To sustain current programmatic levels, a total decrease of $6,470,438 in proposed PEI funding from the previous fiscal year is reflected in this MHSA Three-Year Plan. Reductions in FY 2017-18 are primarily due to services being funded through other revenue sources.

INNOVATION (INN)

The FY 2017-18 enhancements and new programs below reflect a total increase of $5,024,437 in proposed INN funding from the previous fiscal year. Implementation of the proposed enhancements is pending approval from the State Mental Health Services Oversight and Accountability Commission (MHSOAC).

ENHANCEMENTS: CYCLE 3

- The **Caregiver Connection** program will be enhanced to serve parents and caregivers of latency and adolescent age children in order to address their own behavioral health needs.
- The **Family Therapy Participation** program will expand the training for parent partners to six additional locations, one in each service delivery region, to encourage increased participation in family therapy.
- The **Peer Assisted Transitions** program will expand peer support coaches to a third crisis house to assist clients in the inpatient setting with planned discharge and transition back to the community.
- The **Urban Beats** program will expand to the North Central region, add an East African component, add transportation for participants to increase engagement and access to treatment, reduce stigma, and enhance cultural expression to the transition age youth (TAY) community.

- The **Cognitive Rehabilitation and Exposure/Sorting Therapy (CREST) Mobile Hoarding Units** program will expand to the South region to diminish long-term hoarding behaviors in older adults.
- The **Evaluation** of enhanced and new INN programs will extend and expand services for data collection and evaluation.

NEW PROGRAMS: CYCLE 4

The new proposed programs will begin in FY 2017-18 or FY 2018-19.

- The **Peripartum Services** program will partner with Public Health Nurses who screen parents from unserved or underserved populations for perinatal mood and anxiety disorders, provide treatment, and linkages to appropriate resources. The goal is to decrease negative consequences from untreated behavioral health issues. This program is proposed to begin in FY 2018-19, pending approval of the MHSOAC.
- The **Telemental Health** program will introduce Telemental Health to youth and adults who experience barriers to connecting to behavioral health services following psychiatric hospitalization. Telemental Health is the use of technology and software to provide therapeutic outpatient services. The goal is to decrease recidivism and increase the effectiveness of follow-up engagement and treatment. This program is proposed to begin in FY 2018-19, pending approval of the MHSOAC.
- The **Roaming Outpatient Access Mobile (ROAM) Services** program will deploy two mobile mental health clinics to rural Native American communities in the East and North Inland Regions of San Diego County to improve access and utilization of mental health services. This program is approved by the MHSOAC and is proposed to begin in FY 2017-18.
- The **Recuperative Services Treatment (ReST) Recuperative Housing** program will connect TAY who are homeless or at-risk of homelessness after being discharged from acute emergency mental health care, engage in services to prevent future admissions to acute emergency settings. This program is approved by the MHSOAC and is proposed to begin in FY 2017-18.
- The **Medication Clinic** program will provide psychotropic medication support for children and youth who have stabilized clinically, but require complex medication management so they can participate in school, community activities, and a rich home life. This program is approved by the MHSOAC and is proposed to begin in FY 2018-19.

WORKFORCE EDUCATION AND TRAINING (WET)

The FY 2017-18 enhancements below reflect a neutral financial impact in proposed WET funding from the previous fiscal year. One-time MHSA WET funding that the County of San Diego initially received upon implementation of the MHSA is nearly exhausted, therefore, CSS funds are being transferred annually to continue WET programs.

ENHANCEMENTS

- The **Behavioral Health Training Curriculum (BHETA)** program will be enhanced to ensure ongoing workforce development and implementation of best practices in serving the County of San Diego's behavioral health population.
- The **Community Psychiatry Residency Training** program will be augmented to enhance the residency track in community psychiatry through the participation of residents in clinical rotations at County operated and County funded behavioral health programs, as well as at the San Diego County Psychiatric Hospital.

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

The FY 2017-18 enhancements and new programs below reflect a total increase of $4,293,767 in proposed CFTN funding from the previous fiscal year. MHSA regulations require CFTN funds to be spent by June 30, 2018. CFTN funds were received as a one-time allocation and the balance has steadily decreased. In FY 2016-17 and FY 2017-18, CSS funds may be transferred to complete CF projects.

ENHANCEMENTS

- The **North Coastal Mental Health Clinic Facility** enhancement will ensure the completion of the remodel and expansion of the facility to improve access to mental health services for residents of the North Region.
- The **North Inland Region Crisis Residential Facility** enhancement will ensure the completion of the facility to improve access to crisis residential services for residents of the North Region.
- The **Children's Emergency Screening Unit (ESU) in Hillcrest** enhancement will ensure the completion of the facility, which will be relocated to a more centralized area of the County of San Diego and expanded from 4 to 12 beds, ensuring improved accessibility for youth needing emergency crisis stabilization services.

NEW PROGRAMS

- **Six Technical Staff to Assist with the Roadmap into Millennium** will begin planning for the transition to an upgraded electronic health records system, Millennium, scheduled to be operational in 2024.
- The **ConnectWellSD Data Exchange Interoperability** project will build an electronic information sharing hub that will leverage new technology to allow County staff and contractors to share information with each other and their customers. ConnectWellSD will improve data gathering, reporting, communication, and coordination of County services.
- The **Financial Management System** will assist staff in efficiently managing MHSA resources and will ensure operational efficiency and cost effectiveness in mental health administration by creating a centralized financial system capable of day-to-day budget management, year-to-date revenue and expenditure monitoring, financial information for contracts and business analytics tools, including standard reports, dashboards , and queries.

LIVE WELL SAN DIEGO

Live Well San Diego is the County of San Diego's vision for a region that is healthy, safe, and thriving. This regional vision, adopted by the County of San Diego Board of Supervisors in 2010, aligns the efforts of individuals, community partners, and government to help over 3 million San Diego County residents live well.

There are three components of *Live Well San Diego*:

1. **Building Better Health:** Improving the health of residents and supporting healthy choices.
2. **Living Safely:** Ensuring residents are protected from crime and abuse, neighborhoods are safe, and communities are resilient to disasters and emergencies.
3. **Thriving**: Cultivating opportunities for all people and communities to grow, connect, and enjoy the highest quality of life.

The implementation of MHSA programs supports the four strategic approaches in advancing the *Live Well San Diego* vision. Examples of MHSA programs that support the *Live Well San Diego* vision include:

1. **Building a Better Service Delivery System**: Improving the quality and efficiency of County government and its partners in the delivery of services to residents and contributing to better outcomes for clients and results for communities.
    - The addition of treatment slots and support services in support of **Project One for All (POFA)** will assist homeless individuals with SMI who are eligible for supportive housing in their recovery.
    - The addition of Probation Officers in several programs and Mental Health Clinicians in the South and Central Region Courts will further enhance **collaboration with Public Safety** to ensure system-involved persons are connected to appropriate services.
    - The addition of ten **Psychiatric Emergency Response Teams (PERT)** will further enhance the delivery of crisis services throughout the County of San Diego.
    - The implementation of the **Our Safe Place** program will provide mental health treatment, referral and linkage for assistance with medical needs, support services for caregivers and LGBTQ youth, drop-in centers, crisis support, and system trainings for LGBTQ youth and various unserved and underserved population.
    - The implementation of the **I-CARE program for Commercially Sexually Exploited Children (CSEC)** in partnership with Child Welfare Services will provide mental health services, life skill training, support groups, survivor led trainings and groups, a drop-in center and crisis support for CSEC, and unserved and underserved populations.

2. **Supporting Positive Choices:** Providing information and resources to inspire County residents to take action and responsibility for their health, safety, and well-being.
    - The **Suicide Hotline** provides trained counselors available through the Access and Crisis toll-free phone line 24 hours a day, 7 days a week to all residents of the County of San Diego.
    - The **It's Up to Us** program provides awareness and understanding of mental illness, suicide prevention, and stigma reduction through the www.Up2SD.org media campaign to all residents of the County of San Diego.

3. **Pursuing Policy and Environmental Changes:** Creating environments and adopting policies that make it easier for everyone to *Live Well* and encouraging individuals to get involved in improving their communities.
    - The completion of the **North Coastal Mental Health Facility** will increase capacity and improve access for unserved and underserved persons in North County.
    - The completion of the **Children's Emergency Screening Unit (ESU)** will expand crisis services for children and improve accessibility in a centrally located area of the County of San Diego.
    - Fully funding the **Crisis Stabilization Units (CSU) in North County** will improve access to crisis stabilization services for persons residing in North County.
    - Partnering with **Public Safety** to co-locate Mental Health Clinicians at the Lemon Grove Family Resource Center will improve access to the appropriate services for system-involved persons.

4. **Improving the Culture Within:** Increasing understanding among County employees and providers about what it means to Live Well and the role that all employees play in helping County residents *Live Well.*
    - **The Cultural Competency Academy** provides intensive cultural competency training tracks with curriculum tailored to enhance specific job responsibilities for County and County-contracted behavioral health providers to ensure culturally competent services are provided.
    - **Community events** hosted and supported by the County, including walks for mental health, suicide prevention, and recovery enhance the understanding of mental health among County employees, providers, and the community.

Implementation of the MHSA programs demonstrates the County's commitment to putting *Live Well San Diego* into action by collaborating with stakeholders, partners, and businesses to align services that promote healthy, safe, and thriving communities for all residents. The *Live Well San Diego* vision is greater than any one organization can accomplish alone. *Live Well San Diego* involves a collective effort in which all of us work together toward a shared purpose to achieve meaningful change. *Live Well San Diego* Partners make a formal commitment to support the vision and include health care providers, community and faith-based organizations, businesses, school districts, cities, tribal governments, and military or veterans organizations. By strengthening connections with these partners and leveraging collective impact, the County is advancing the vision of a healthy, safe, and thriving region.

SAN DIEGO COUNTY DEMOGRAPHICS

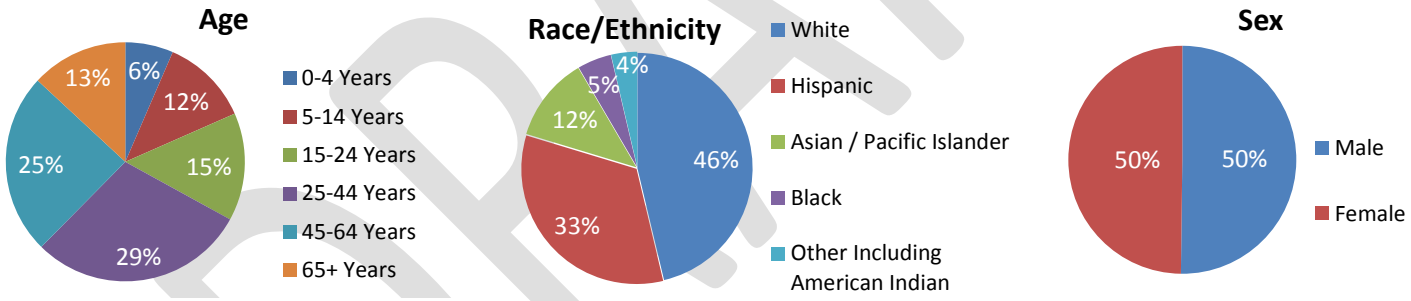
San Diego County in California is located near the Pacific Ocean in the far southwest part of the United States. The county encompasses 4,526 square miles, has nearly 70 miles of coastline, lies just north of Mexico, and shares an 80-mile international border. It is among the nation's most geographically varied regions with urban, suburban, and rural communities throughout coastal, mountain, and desert environments. San Diego County's estimated population in 2016 was 3,288,612[1], making it the second-most populous county in California and the fifth-most populous county in the United States.

Total Housing Units[1]: 1,185,498

Total Households	Vacancy Rate	Median Household Income (Adjusted for Inflation):
1,126,029	5%	$63,403

San Diego County is home to world class universities, an innovative healthcare industry, and a large military presence. According to the San Diego Regional Economic Development Corporation[2], the healthcare industry is one of the fastest growing, and one of the largest employers in the region. San Diego is a leader in health innovation due in part to its *Live Well San Diego* vision to build a healthy, safe, and thriving community. The region is home to 25 hospitals, and more than 26,000 unique healthcare and social assistance establishments that employ more than 140,000 people. Healthcare companies provide more than $6.9 billion in wages annually. Furthermore, the local military industry accounted for nearly $8 billion in federal contracts in 2016, and one of every five jobs was directly linked to the military or due to military spending in the region. There are an estimated 233,863 veterans residing in San Diego.

As of January 1, 2016, the estimated demographics for San Diego County were as follows:



The region is expected to further diversify with a steady increase in the Hispanic population. The two most spoken languages at home are English and Spanish. Nearly 22% of county residents are bilingual. Additionally, the county's threshold languages continue to be Spanish, Vietnamese, Arabic, and Tagalog.

On January 27, 2017, the Regional Task Force on the Homeless conducted its annual Point-in-Time Count of homeless individuals living in San Diego County. The findings showcased that the total number of homeless has increased approximately 5% from 8,692 in 2016 to 9,116 in 2017. Surveys indicated that 20% of the homeless individuals experience substance use disorder (SUD) issues, 39% self-reported mental health issues, 29% are victims of domestic violence, 8% are unsheltered veterans, and 40% have a physical disability. Overall, 31% of these individuals experience chronic homelessness.

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

[1] Based on the SANDAG January 1, 2016 population estimates.

[2] San Diego Regional Economic Development Corporation: http://www.sandiegobusiness.org/sites/default/files/Healthcare%20Profile_0.pdf

COMMUNITY PLANNING PROCESS (CPP)

The most recent Community Planning Process (CPP) for Behavioral Health Services (BHS) consisted of conducting a series of public forums and focus groups during the fall of 2016 and gathering input from the system of Councils led by stakeholders, which represent public, provider, and client interests. Input informed each phase of planning, from annual budgeting and program development to the formation of Innovation Plans and the Behavioral Health Services Ten Year Roadmap.

STAKEHOLDER INPUT

From September through November 2016, more than 550 people participated in 12 community forums, and more than 100 individuals joined in 6 specialty focus groups. Attendees engaged in an adapted World Café process conducted by social science evaluation and research firm Hoffman Clark and Associates. The method was designed to capture each group's perspective and yield a workable ranking of priorities to guide decision-making and planning. Results have been compiled in a comprehensive report and as an interactive online database available at www.hoffmanclark.org. The World Café's evidence-based constructivist approach engages each participant through discussion. In other words, ideas are not just collected from each person, but individuals' ideas emerge through engaged discussion with each other. Below is an excerpt summary from the consultant's report, included in full as Appendix H.

- Participants in the 2016 community engagement process valued the opportunity to have their voices heard. More than 650 stakeholders, including providers, consumers, and community members came to the table to envision a bright future for BHS and to provide input on how to affect meaningful change.
- The community expressed a need for home-based services and services embedded in schools, including education programs and campaigns targeting parents, teachers, school staff, and students to enhance awareness of behavioral health issues, normalizing and destigmatizing these issues, and teaching skills for managing them.
- Across all regions, the need for culturally competent services was noted along with suggestions for consumer-driven and peer-led services. Other requests included stigma reduction, public education, and the establishment of mobile and one-stop centers of care.
- The issues of housing and transportation are closely connected to behavioral health and cut across the areas of care coordination, unserved and underserved populations, and Children's Behavioral Health. Participants offered solutions in these areas, ranging from simple suggestions from providing BHS consumers with greater access to bus passes to innovative ideas on addressing homelessness.

FORUMS AND FOCUS GROUPS

The CPP included additional focus groups for special populations to gather actionable items for system improvement. The groups included the Public Safety Planning Group (Justice Partners), National Alliance on Mental Illness (NAMI) and RI International (Peer Workers), Indian Health Council (Native American community), Live Well Communities Task Force (Southeastern San Diego community), and two detention populations, including one female, within Los Colinas Detention & Reentry Facility, and one male, within the George F. Bailey Detention Facility. Identified strategies and actionable solutions are included in Appendix H.

COUNCILS AND WORK GROUPS

BHS organizes, supports and participates in more than a dozen local, state, and national councils and work groups. Local councils include providers, consumers, and other stakeholders who give feedback, hear updates, help identify the community's needs, and the most effective interventions to meet those identified needs. Monthly meetings are attended by the BHS Director and leadership team.

In addition to regular meetings, council members gather as committees to consider proposals and reports, draft letters, and form consensus. For example, the Innovation programs summarized in this MHSA Three-Year Plan include concepts developed in councils, considered and vetted by committees, and finalized with feedback through the council system. Councils and work groups also incorporate reports into their strategic planning and goal setting. The BHS Director regularly communicates with councils and work groups to provide state policy and local system updates.

BEHAVIORAL HEALTH ADVISORY BOARD

The County's Behavioral Health Advisory Board (BHAB) is comprised of consumers, family members, prevention specialists, and professionals from the mental health and SUD fields, representing each of the five County supervisorial districts. Annual update information and input requests are mailed to all BHS stakeholder distribution lists, including the San Diego Mental Health Coalition, Mental Health Contractors Association, and the Hospital Partners Association. BHAB is the site of public hearings that follow the 30-day public review for annual updates and all plan changes prior to submission to the County of San Diego Board of Supervisors.

CULTURAL COMPETENCY RESOURCE TEAM

The Cultural Competency Resource Team (CCRT) supports the County's Cultural Competence Plan. Members are appointed by the Deputy Directors of BHS, representing units and disciplines within BHS, as well as members-at-large, including consumers and family representatives. Key participants include BHS Quality Improvement (QI), the Mental Health Contractors Association, and behavioral health providers. The BHS/State Ethnic Services Coordinator, currently the Deputy Director of the BHS Adult and Older Adult System of Care, acts as primary staff support.

ADULT BEHAVIORAL HEALTH SERVICES SYSTEM OF CARE COUNCIL

This council provides input on the needs and programs associated with adults.

BEHAVIORAL HEALTH SERVICES HOUSING COUNCIL

This council provides input on the needs and programs associated with homelessness and housing for persons with SMI.

CHILDREN, YOUTH AND FAMILIES BEHAVIORAL HEALTH SERVICES SYSTEM OF CARE COUNCIL

This council provides input on needs and programs associated with children, youth, and families.

OLDER ADULT BEHAVIORAL HEALTH SERVICES SYSTEM OF CARE COUNCIL

This council provides input one the needs and programs associated with older adults and caregivers.

TRANSITION AGE YOUTH BEHAVIORAL HEALTH SERVICES SYSTEM OF CARE COUNCIL

This council provides input on the needs and programs associated with transition age youth 16 to 25 years old.

MHSA THREE-YEAR PROGRAM AND EXPENDITURE PLAN

The County of San Diego's Mental Health Services Act (MHSA) planned expenditures for FY 2017-18 are estimated at **$197,523,661**. Funding for MHSA programs is determined based on the priorities identified during the CPP and evaluation of whether programs are achieving the desired outcomes.

Expenditure plans for each of the five MHSA components are included in the chart below. See Appendix A for the detailed MHSA Expenditure Plan for FYs 2017-18, 2018-19 and 2019-20.

MHSA Component	FY 2017-18		FY 2018-19		FY 2019-20	
	Budget	*%*	*Budget*	*%*	*Budget*	*%*
Community Services and Supports (CSS)	$137,475,041	69.6%	$136,822,442	72.9%	$136,822,442	74.3%
Prevention and Early Intervention (PEI)	$35,398,218	17.9%	$31,923,785	17.0%	$31,923,785	17.3%
Innovation (INN)	$11,168,543	5.7%	$15,731,162	8.4%	$12,099,668	6.6%
Workforce Education and Training (WET)	$2,984,483	1.5%	$3,291,710	1.8%	$3,296,741	1.8%
Capital Facilities and Technological Needs (CFTN)	$10,497,376	5.3%	$0	0.0%	$0	0.0%
Total MHSA Budget*	**$197,523,661**	**100%**	**$187,769,099**	**100%**	**$184,142,636**	**100%**
*All figures are rounded to the nearest whole number.						

PROGRAM IMPLEMENTATION

The MHSA addresses a broad continuum of prevention, early intervention and service needs, and the necessary infrastructure, technology, and training elements to effectively support the public mental health system. Within Behavioral Health Services (BHS), MHSA services are largely provided through a competitive procurement process, many contracts of which are awarded to community-based service providers. To ensure quality services are provided, teams of subject-matter experts within BHS oversee services through regular contract monitoring and communication with service providers.

MHSA programs are client-centered, culturally aware, and employ detailed measures of strategic outcomes. Outcomes include clinical and functional improvement or stabilization, progress toward client goals, and client satisfaction. Programs may be funded through multiple contracts and in various locations throughout San Diego County to ensure reasonable access for all residents. Contracts emphasize cultural competency and access to unserved and underserved communities through standard tools such as the federal Culturally and Linguistically Appropriate Services (CLAS) tool. Unserved and underserved communities are the focus in contracts, and stigma reduction and trauma-informed care strategies are embedded in all programs and contracts.

COLLECTING DATA AND MEASURING OUTCOMES

What is the impact of what we do? Do our services add value? Are people's lives improved? The importance of answering these questions accurately is reflected in the extraordinary effort BHS takes in measuring the outcomes of MHSA programs. Data is regularly collected, analyzed, and reported in monthly, quarterly, and annual reports by the BHS Quality Improvement (QI) team to determine if services are meeting expected outcome measures. The Performance Improvement Team (PIT) also monitors targeted aspects of care on an on-going basis. Data is analyzed

over time to determine whether program outcomes are being met and inform decision making. Additionally, BHS regularly shares data reports during the Community Planning 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 serves as the Administrative Services Organization (ASO) for BHS, facilitating the County's role in administering certain inpatient and outpatient Medi-Cal and realignment-funded specialty mental health services. Optum conducts ongoing quality review of therapy treatment plans and evaluation reports prepared for Child Welfare Services (CWS) cases and evaluation reports prepared for Juvenile Probation cases. It also 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 and substance use disorders (SUD), access to emergency mental health services, and other services.

CHILD AND ADOLESCENT SERVICES RESEARCH CENTER

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 San Diego (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 high risk for the development of mental health problems or disorders.

HEALTH SERVICES RESEARCH CENTER

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

The Research Centers work 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 Three-Year Plan and full reports are attached in Appendices D, E, F and G.

COMMUNITY SERVICES AND SUPPORTS

Community Services and Supports (CSS) represents the largest component of the Mental Health Services Act (MHSA), accounting for approximately 70% of the total budget. The goal of CSS programs is to transform the mental health system by promoting early intervention and recovery. These programs provide direct services to fully meet the needs of persons struggling with mental illness. Services provided are wellness focused, client and family driven, and designed to create an integrated service experience. Teams within BHS are assigned to different populations, including children, youth and families (CYF) and adults and older adults (AOA), which includes transition age youth (TAY).

FULL SERVICE PARTNERSHIPS

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, housing, medical care, and job- or life-skills training.

SYSTEM DEVELOPMENT

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-based clinical practices.

OUTREACH AND ENGAGEMENT

Outreach and Engagement (OE) programs target populations that are currently receiving little or no service. This effort includes unserved 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 work in conjunction with racial/ethnic community-based organizations, mental health and primary care partnerships, faith-based agencies, tribal organizations and health clinics, and organizations that help individuals who are homeless or incarcerated. Outreach services link potential clients to services.

WORKFORCE EDUCATION AND TRAINING

Workforce Education and Training (WET) programs provide support, education, and training to the public mental health workforce to assist with the shortage of qualified individuals who provide services to persons with mental illnesses in the County of San Diego. WET funds were received as a one-time allocation and the balance of WET funds has steadily decreased. In FY 2017-18, approximately $2.9 million in CSS funds will be transferred to the WET component to continue funding programs identified in the WET section of this report. The need for additional WET funds will be evaluated annually.

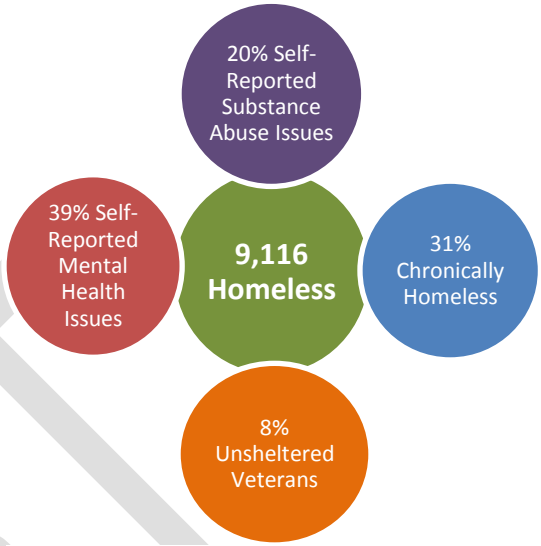
CAPITAL FACILITIES

Capital Facilities (CF) funds may be used to acquire, develop, or renovate buildings or to purchase land in anticipation of constructing a building to improve mental illness service delivery. CF funds were received as a one-time allocation and the balance has steadily decreased. In FY 2016-17 and FY 2017-18, CSS funds may be transferred to complete projects.

CSS Housing Program

Housing matters because home is where recovery begins. Having a safe place to live while receiving mental health and social services can break the cycle of homelessness. Addressing the dual stigmas of homelessness and mental illness on a large scale requires collaborative partnerships among various service providers and agencies, including housing developers and local and State agencies. The MHSA provides an array of housing options dedicated to help persons with behavioral health issues begin their recovery including:

- Short Term and Bridge Housing (formerly Emergency Shelter Beds)
- Augmented Services Program (ASP) within Licensed Board & Care (B&C) facilities
- Independent Living
- Transition in Place/Rapid Rehousing
- Transitional Housing
- Permanent Supportive Housing
- Affordable Housing



2017 Point-in-Time Count

Currently, there are 15 County MHSA supportive housing developments across the county, with an investment of over $33 million in MHSA funding and providing 241 permanent supportive units. An additional $10 million in funding has been set-aside for permanent supportive housing developments which will result in the establishment of an additional 65 to 70 housing units in collaboration with housing developers and housing authorities. Participants in supportive housing hold their own leases, contribute to rent, and are subject to the same rules and regulations as other tenants. These supportive housing developments make up just one of the many elements of the MHSA supportive housing program. As of June 2017, 1,486 formerly homeless persons with a serious mental illness were receiving BHS-contracted ACT services paired with an array of housing options. A detailed report of the Housing Projects funded through CSS may be found in Appendix K.

Project One for All

Project One for All (POFA) is an ambitious, community-driven goal to house 1,250 people with SMI by the end of 2018. Enacted in February 2016 by the County of San Diego Board of Supervisors, POFA combines wraparound mental health services with permanent housing for people who are homeless and have SMI. POFA fully integrates housing, mental health services, primary health care, SUD services, case management, and social services to help ensure participants achieve stable and productive lives. The total estimated investment in POFA by the end of FY 2017-18 will be over $25 million.

Local housing authorities have committed 1,103 housing vouchers to POFA, with the goal of an additional 147 vouchers by 2018. In an effort to achieve optimal collaboration, Housing & Community Development Services (HCDS) was integrated into the Health and Human Services Agency in FY 2016-17.

JUSTICE, COURT AND PROBATION PROGRAMS

The BHS integrated system of care presents various opportunities to reach clients involved in the justice system. Many MHSA programs provide access and support for individuals either entering or exiting juvenile detention, prison, or the courts. Programs work in full collaboration with the San Diego County Sheriff, the County of San Diego Probation Department, and other law enforcement agencies to support successful reintegration 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. The total estimated investment in justice related MHSA programs by the end of FY 2017-18 is over $33 million.

See Appendix M for a list of MHSA-funded programs for criminal justice involved clients.

THE ROAD AHEAD

Governor Brown signed the No Place Like Home (NPLH) program into legislation on July 1, 2016. The program dedicates $2 billion in bond proceeds to invest in the development of permanent supportive housing for persons who are in need of mental health services and are experiencing homelessness or at risk of homelessness. These bonds will be repaid with funds from the MHSA.

Counties will be eligible applicants to receive funding for permanent supportive housing and must utilize low barrier tenant selection practices that prioritize vulnerable populations and offer flexible, voluntary, and individualized supportive services. Counties must commit to provide mental health services and help coordinate access to other community-based supportive services. NPLH funds are estimated to be available in 2018.

For more information, please visit the No Place Like Home website: http://www.hcd.ca.gov/grants-funding/active-funding/nplh.shtml

CSS PROGRAMS FOR CHILDREN, YOUTH AND FAMILIES (CYF)

MHSA programs for children, youth and families (CYF) treat children (age 0-11) and youth/adolescents (age 12-17), as well as transition age youth (TAY) (age 16-21) with serious emotional disturbance (SED) who may have co-occurring disorders and their families.

The programs below are grouped in the Expenditure Plan (Appendix A) by the work plan acronym in parentheses.

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

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $28,622,970

SCHOOL-BASED AND CLINICAL SERVICES

Location is crucial in effectively connecting children with services. Access to care for young people has improved because of increased funding for services in existing neighborhood outpatient clinics and through the introduction of comprehensive clinical offices on school campuses. Known as Full Service Partnerships (FSP) because of their broad approach, outpatient clinical offices are staffed where the needs are greatest. Available countywide, FSP programs serve children and young adults up to the age of 21. These clinics now offer case management, rehabilitation and SUD counseling, in addition to psychiatric evaluation, medication monitoring, and crisis intervention. Clinicians work with families on a variety of unmet needs that may impact resiliency and help develop a wellness plan for parents to organize their child's medical information.

School-based programs conduct outreach and engagement and offer integrated co-occurring disorders treatment. The transformation to FSPs began on January 1, 2016, and continues to emphasize whole-person wellness and a "whatever it takes" approach in order to establish stability and maintain engagement. FSPs build on client strengths and assist in the development of abilities and skills so clients can achieve self-identified goals. This program involves dozens of clinics and hundreds of schools.

- *POPULATION*: Children, youth, and TAY with SED and their families.
- *KEY OUTCOMES*: Develop and strengthen resiliency, increase family participation and completion of Wellness Notebook, an evidence-based intervention.
- *KEY MEASUREMENTS*: FSP providers collect outcome data with the Child and Adolescent Measurement System and the Children's Functional Assessment Rating Scale. The data measures a child's social competency, behavioral and emotional needs, and whether the child is stabilizing or improving.

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

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $10,244,948

LESBIAN, GAY, BISEXUAL, TRANSGENDERED OR QUESTIONING SERVICES

Our Safe Place is a new program designed to provide a full range of mental health treatment services for LGBTQ youth. Multiple drop-in centers in different regions of the County will provide supportive services to any youth who identifies

as Lesbian, Gay, Bisexual, Transgendered, and Questioning. The drop-in centers will have support groups for youth, family members and/or caregivers, youth partners, and alumni mentorship programs.

- *POPULATION:* LGBTQ youth and TAY who need supportive services with treatment and for those who meet SED criteria.
- *KEY OUTCOMES:* Decrease mental illness and trauma for LGBTQ youth, reduce LGBTQ stigma and discrimination, increase the community's understating of LGBTQ youth, and provide community outreach and trainings to improve overall outcomes for LGBTQ youth.
- *KEY MEASUREMENTS:* Pending program implementation.

COMMERCIALLY SEXUALLY EXPLOITED CHILDREN

Multiple programs offer treatment and supportive services to youth who have been or are at risk for commercial sexual exploitation. Funding covers a full range of therapeutic services, as well as survivor advocacy, drop in center, and alumni mentorship programs. Services are offered in the juvenile institutions and shall be expanding to the community through a newly launched countywide program in partnership with Child Welfare Services. Services include individual counseling, family counseling, assessments, parenting groups, positive choices and anger management groups, and crisis interventions.

- *POPULATION:* Youth and TAY who at risk for or are victims of commercial sexual exploitation.
- *KEY OUTCOMES*: Decrease mental illness and trauma for CSEC youth by creating a safe and welcoming environment at the youth drop-in center and outpatient treatment program by providing youth partners who have lived experience, support groups for youth and caregivers, intervention that address past traumas and current behavioral health and substance abuse issues, job skill assessment, and life skill training.
- *KEY MEASUREMENTS:* Pending program implementation.

EMERGENCY SCREENING, WALK-IN ASSESSMENTS AND MOBILE CRISIS TEAMS

Multi-disciplinary teams take a strength-based approach to address children and youth's psychiatric crises. Services include psychiatric crisis screening, stabilization, and linkages to additional services.

- *POPULATION:* Children and youth up to 18 (for the Emergency Screening Unit) who are low income, uninsured, or are Medi-Cal beneficiaries.
- *KEY OUTCOMES:* Reduce the use of emergency and inpatient services, prevent escalation of symptoms and promote management of mental illness.
- *KEY MEASUREMENTS:* Crisis stabilization and diversion from inpatient psychiatric hospitalizations.

EMERGENCY JUVENILE JUSTICE AND PROBATION SERVICES

Children in the juvenile justice system face a difficult road and many are affected by trauma. There are multiple points within this system where behavioral health services are available for both emergent issues and ongoing support. The programs rely on partnerships with the County of San Diego Probation Department, Juvenile Court, and Child Welfare Services (CWS). Services are offered in juvenile detention facilities within the County of San Diego and in the community.

- *POPULATION:* Children and youth with SED who are wards or dependents.

- *KEY OUTCOMES:* Increase in access to services for Probation youth, successful reintegration into the community, and reduction in recidivism and the number of youth in Juvenile Hall.
- *KEY MEASUREMENTS:* Compliance with defined outcome and process objective standards and annual report on provider compliance.

PLACEMENT STABILIZATION SERVICES

A stable home life is the most effective way to prevent children from developing conduct disorders. The CYF System of Care includes more than a dozen programs aimed at keeping children in or returning them to a nurturing home. Services include milieu therapy, individual therapy, group therapy and family therapy, case management, and medication services. Some programs, such as San Pasqual Academy, provide peer mentorship services to CWS youth in placement and foster youth in residential settings. Other programs use Incredible Years evidence-based curriculum to provide services through a family therapy model. Outreach is focused on low income, uninsured or underinsured and Medi-Cal eligible youth, and provide services in designated preschools in high poverty areas. Programs accept referrals from CWS and seek to return children and youth to their families or family-like settings.

- *POPULATION:* Children and youth (with SED) who are at risk of placement in a higher level of care.
- *KEY OUTCOMES:* Reduce placement in higher levels of care, stabilize current placement, strengthen parenting competency, and reduce behavioral challenges.
- *KEY MEASUREMENTS:* Compliance with outcomes defined in the Behavioral Health Services' Organizational Provider Operations Handbook and timely contact following referral.

RURAL INTEGRATED BEHAVIORAL HEALTH AND PRIMARY CARE / SMART CARE

San Diego County has a rural expanse of mountains and deserts. The health needs of people living in rural areas are served in part by a network of clinics that integrate behavioral health services by offering psychiatric access over the phone. Both CSS and Prevention and Early Intervention (PEI) services are available in rural community clinics. Paraprofessional behavioral health educators strive to prevent patients from developing SMI or addiction by addressing behavioral health needs early. Programs help patients manage health, emotional, and behavioral concerns to help improve their wellness. The Smart Care program offers real time access to psychiatric consultation throughout the County including primary physicians in rural clinics.

- *POPULATION:* Residents and clinic patients in rural areas.
- *KEY OUTCOMES:* Increase in access, reduce symptoms, reduce stigma and discrimination, increase awareness in community and among clinic staff, and increase integration of services.
- *KEY MEASUREMENTS:* Completion of a client satisfaction survey, monthly and annual number of psychotherapeutic drugs prescribed at clinics, and completion of a satisfaction survey.

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

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $1,884,300

PERINATAL OUTPATIENT HOMELESS OUTREACH AND INCREDIBLE YEARS

The perinatal outpatient homeless outreach program provides services through existing SUD programs for women who may have a SMI and co-occurring disorders, to any women seeking treatment. The Incredible Years program uses evidence-based curriculum to provide services through a family therapy model. Children of substance abusing parents are widely considered to be at high risk for a range of biological, developmental, and behavioral problems, including

developing a SUD. These programs provide a team-based, "whatever it takes" approach to support homeless and runaway children, and TAY with SED. Assertive outreach and strong connections to community resources are emphasized.

- *POPULATION:* Homeless and runaway children, TAY diagnosed with SED, uninsured and underserved, with a secondary focus on Medi-Cal underserved, and pregnant and parenting women.
- *KEY OUTCOMES:* Address SUD problems, eliminate criminal activity, enhance parenting skills, screen for co-occurring disorders, provide appropriate referral to treatment, engage in employment preparation, retention in treatment, and deliver infants who are drug free.
- *KEY MEASUREMENTS:* Compliance with Children's System of Care goals as defined in the Behavioral Health Services' Organizational Provider Operations Handbook.

CSS PROGRAMS FOR TRANSITION AGE YOUTH ADULTS AND OLDER ADULTS (TAOA)

MHSA programs for individuals 18 years of age and older treat transition age youth (TAY) (age 18-25), adults (age 26-59) and older adults (age 60+) (TAOA). Individuals with serious mental illness (SMI) or co-occurring disorders and their families are the target population.

The programs below are grouped in the Expenditure Plan (Appendix A) by the work plan acronym in parentheses.

TRANSITION AGE YOUTH, ADULTS AND OLDER ADULTS - FULL SERVICE PARTNERSHIPS (TAOA-FSP)

FSP programs represent the combined efforts of eight community-based organizations, along with partnerships with the County of San Diego Probation Department and law enforcement. FSPs operate within the scope of more than 50 BHS contracts.

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $38,125,304

INTEGRATED SERVICES AND SUPPORTIVE HOUSING, INCLUDES PROJECT ONE FOR ALL (POFA)

These programs represent a team-based "whatever it takes" approach to support clients to attain housing and employment. The goal is to reduce homelessness by providing comprehensive wraparound mental health services to adults with SMI, in need due to severe functional impairments, and who have not been adequately served by the current system. POFA launched in 2016, aiming to create sustainable housing for 1,250 individuals with SMI. This initiative provides access to Section 8 subsidies through the San Diego Housing Commission, Housing Community Development, and other housing authorities. Additionally, Strength-Based and Intensive Case Management programs for homeless clients operate in all regions of the County and pair treatment with supportive housing.

- *POPULATION:* Adults with SMI who are homeless or at risk of becoming homeless, including high users of inpatient care, medical services, or locked long-term care facilities. Specific programs target outreach to underserved populations, including African-Americans and women, TAY, older adults, and homeless clients that are system involved.
- *KEY OUTCOMES:* Increase service use for TAY, decrease homelessness, increase in self-sufficiency through development of life skills, rehabilitate adults who have high service use and are discharged from long-term care facilities, clinical and/or functional improvement or stabilization, improve housing status, progress toward individual employment and educational goals, timely transition to permanent housing, linkage to primary care, satisfaction of client, assessment for SUD, and family contact.
- *KEY MEASUREMENTS:* Monitor fidelity to ACT standards, quarterly reporting of ACT data, strengths assessment administered at admission and updated annually, and a satisfaction survey completed at discharge.

INTENSIVE CASE MANAGEMENT

Effective recovery starts with meeting the basic needs of persons with SMI. Intensive case management services utilize ACT, an evidence-based practice that utilizes an interdisciplinary team approach to provide mental health services, intensive case management, rehabilitation, and recovery services that are connected to supportive housing and employment supports. The interdisciplinary teams blend the knowledge and skills of psychiatrists, nurses, mental health professionals, employment specialists, peer specialists, and SUD specialists who join together to give clients ongoing, individualized care. Teams work toward preventing unnecessary hospitalization, improving quality of life, and improving client functioning. The programs rely on evidence-based models of intervention, such as ACT and Strength-Based Case Management (SBCM).

- *POPULATION:* Adults diagnosed with SMI who are users of acute psychiatric inpatient care or acute psychiatric inpatient care, and Medi-Cal eligible or indigent. Specialized programs focus on TAY, older adults, and persons that are homeless or at-risk of homelessness with SMI.
- *KEY OUTCOMES:* Reduce psychiatric hospitalizations, reduce incarceration, improve community support, clinical and/or functional improvement or stabilization, improve housing status, progress toward individual employment and educational goals, enroll in Section 8 housing, family contact, enroll in a Wellness Recovery Action Plan (WRAP), and client satisfaction.
- *KEY MEASUREMENTS:* Submission of required data elements monthly and quarterly, completion of a satisfaction survey, and assess for SUD.

JUSTICE INTEGRATED SERVICES AND SUPPORTIVE HOUSING

Clients transitioning from the justice system need specialized care to attain housing and stability in the community. In partnership with the County of San Diego Probation Department, these programs provide comprehensive wraparound mental health services for adults who have a serious mental illness, have severe functional impairments, and have not been adequately served by the current system. These services are based on evidence-based biopsychosocial rehabilitation (BPSR) principles that are person-centered, integrate mental health and co-occurring substance use treatment, and recovery services to improve mental health and quality of life and prevent recidivism. Programs serve homeless TAY, adults and older adults. Individuals who are no longer in need of intensive case management are transitioned to lower levels of care to include SBCM and outpatient services.

- *POPULATION:* Adults diagnosed with SMI, who are homeless or at risk of becoming homeless and have an active or recent criminal justice involvement, high users of inpatient care, medical services or locked long-term care facilities, and re-entering the community from the justice system. Various programs focus on unserved and underserved populations, including African-Americans, women, TAY, and older adults.
- *KEY OUTCOMES:* Reduce incarceration, use of unnecessary acute care, institutionalization, and homelessness, improve housing status, successful completion of the program, progress toward achieving self-directed employment goals, and functional improvement or stabilization.
- *KEY MEASUREMENTS:* Monitor fidelity to ACT standards, quarterly reporting of ACT data, assessment of SUD, completion of a client satisfaction survey, and monitor compliance with dual diagnosis enhanced criteria implemented in accordance with approved plan.

TRANSITION AGE YOUTH, ADULTS AND OLDER ADULTS – SYSTEM DEVELOPMENT (TAOA-SD)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $32,811,575

CLUBHOUSE AND PEER SUPPORT SERVICES

Clubhouses aim to increase client self-sufficiency through the development of life skills, creating and maintaining relationships, sustaining housing, and supporting employment and education. Programs are designed for TAY, adults and older adults with SMI who are in need of social and recreational activities, skill development, and employment and education opportunities. Recovery activities focus on the strengths and abilities of member participants. There are more than a dozen clubhouses in operation in all regions of the County. Some sites provide Social Security Income (SSI) advocates who review and submit SSI applications for non-General Relief clients.

- *POPULATION:* Adults, older adults, TAY, and Veterans with SMI.
- *KEY OUTCOMES:* Increase access to mental health services, increase self-sufficiency, support and sustain housing, education and employment, progress on relief applications, progress with individual vocational goals, enroll in field-based programs, and client satisfaction.
- *KEY MEASUREMENTS:* Track and submit aggregated participant outcomes based on individual goals, attain field-based program measures, and completion of client satisfaction surveys.

BEHAVIORAL HEALTH COURT, DISCHARGE PLANNING AND ADVOCACY

This program provides comprehensive, integrated and culturally-competent mental health services for individuals with SMI who have been found guilty of a non-violent crime and are awaiting sentencing. The goal is to reduce incarceration and institutionalization, increase meaningful use of time and capabilities, reduce homelessness, and provide timely access to services.

- *POPULATION:* Adults and older adults referred for services via the justice system and repeat offenders who may have received mental health services while incarcerated or in the community.
- *KEY OUTCOMES:* Reduce incarceration, institutionalization, and homelessness, and increase access to services.
- *KEY MEASUREMENTS:* Monitor collection of records and outcomes.

AUGMENTED SERVICES PROGRAM

The Augmented Services Program (ASP) targets individuals in licensed Board and Care facilities (B&C). The goal of the ASP program is to provide additional services to persons with serious and prolonged mental illness in licensed residential care facilities. Services are available at twelve licensed Board and Care facilities.

- *POPULATION:* Adults with SMI currently in licensed B&C.
- *KEY OUTCOMES:* Maintain or improve client functioning in the community and prevent or minimize institutionalization.
- *KEY MEASUREMENTS*: Monitored achievement of client-identified outcome goals, presenting as improved functioning in the community.

SHORT TERM AND BRIDGE HOUSING (FORMERLY EMERGENCY SHELTER BEDS)

Bridge Housing programs provide short-term emergency housing in a residential setting where staff are available at all times. They provide safe and sanitary quarters on a nightly basis and coordinate services with designated County-contracted Homeless Outreach Workers (HOW) and Peer Support Services. The goal is to decrease homelessness for

persons with serious mental illness. Programs provide both emergency and transitional housing. All persons referred for services are screened by a mental health Homeless Outreach Worker to determine eligibility and coordinate services. Services are required to be trauma-informed, provide linkage to faith-based communities, and meet federal standards for Culturally and Linguistically Appropriate Services (CLAS). There are nine sites located countywide.

- *POPULATION:* Homeless TAY, adults and older adults with SMI who have no stable income.
- *KEY OUTCOMES:* Reduce homelessness, increase self-sufficiency, access to services, and reduce institutionalization.
- *KEY MEASUREMENTS:* Provision of assessment and linkage to mental health, physical health, and social services.

SHORT TERM ACUTE RESIDENTIAL TREATMENT

Short Term Acute Residential Treatment (START) is voluntary for adults with SMI and are experiencing a mental health crisis or in need of intensive, non-hospital intervention. START programs provide crisis residential service 24 hours a day, 7 days a week, as an alternative to hospitalization or step down from acute in-patient care within a hospital.

- *POPULATION:* Adults with SMI and may have a co-occurring SUD.
- *KEY OUTCOMES:* Improve level of functioning, ability to return to the community, and diversion from emergency beds.
- *KEY MEASUREMENTS:* Stability at discharge as measured on the Mental Health Statistics Improvement Program (MHSIP) Outcomes Domain and reduction of readmission to crisis program or hospital within 30 days of discharge.

BIOPSYCHOSOCIAL REHABILITATION

Outpatient programs seek to increase access to mental health services to address severe mental health conditions and co-occurring disorders. Biopsychosocial (BPSR) recovery centers are Medi-Cal certified and provide outpatient mental health rehabilitation medication management, care coordination, recovery services, and employment support for adults with SMI, including those who may have a co-occurring SUD. Some programs have dedicated TAY and older adult geriatric specialists that provide age and developmentally appropriate services that are integrated and culturally appropriate. There are approximately two dozen locations countywide.

- *POPULATION:* TAY, adults, and older adults with SMI, including those who may have a co-occurring SUD.
- *KEY OUTCOMES:* Improve level of functioning, reduce barriers to service, increase in awareness of available services, clinical and/or functional improvement or stabilization, improve housing status, progress toward individual employment and educational goals, linkage to primary care, satisfaction of client assessment, and linkage to SUD programs.
- *KEY MEASUREMENTS:* Functional assessments such as the Milestones of Recovery Scale (MORS), Illness Management Recovery (IMR), and Recovery Markers Questionnaire (RMQ), the annual report of WRAP compliance, completion of a satisfaction survey and completion of annual self-report improvement survey.

MOBILE SERVICES

Mobile services, also referred to as In-Home Outreach Teams (IHOT), seek to engage adults and older adults with SMI who are reluctant to seek treatment. The program is strength-based and person-centered, aiming to build

trusting relationships, address immediate needs, and connect individuals to community resources so they can reach their highest potential. In addition to helping participants connect with community resources, the program educates involved family members by providing them with information and guidance on how to navigate the mental health system and recovery journey. The goal of this program is to reduce the effects of untreated mental illness in individuals with SMI and their families. Originally a short-term Innovation project, IHOT is now an ongoing program operated through two regional community-based organizations.

- *POPULATION:* Adults and older adults.
- *KEY OUTCOMES:* Increase access to services, increase comprehensive outreach, engagement, and follow-up, increase client engagement and participation in treatment, increase client participation in classes, and diversion from hospitalization and/or incarceration.
- *KEY MEASUREMENTS:* Monitor submission of aggregate data and completion of client satisfaction surveys.

TRANSITION AGE YOUTH, ADULTS AND OLDER ADULTS – OUTREACH AND ENGAGEMENT (TAOA-OE)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $750,876

NON-RESIDENTIAL SUD TREATMENT & RECOVERY SERVICES

Non-residential SUD treatment and recovery centers provided services to adults with SUD, including those who may have a co-occurring mental health disorder. Services include assessment and evaluation, treatment groups, individual counseling, care coordination, crisis counseling, life planning skills, self-esteem workshops, anger management, parenting and domestic violence classes, mental health counseling, and relapse prevention. These programs are offered through three community-based agencies, including focus on Asian and Pacific Islander adults, TAY, refugees, immigrants, and other underserved populations. Clients are referred through Drug Court, California Work Opportunity and Responsibility to Kids (CalWORKS), and Child Welfare Services. The programs also welcome walk-ins and self-referrals.

- *POPULATION*: TAY, adults, and older adults with SUD and co-occurring mental health disorders, including centers that focus on serving Asian and Pacific Islanders, refugees, immigrants and other underserved adults.
- *KEY OUTCOMES*: Increase access to services and improve outcomes of self-directed goals, reduced drug use, and reduction in arrests.
- *KEY MEASUREMENTS*: Completion of goals and objectives specified in individualized treatment plans and completion of client satisfaction surveys.

CSS PROGRAMS FOR ALL AGES (ALL)

These programs serve all age groups and are grouped in the Expenditure Plan (Appendix A) by the work plan acronym in parentheses.

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

ESTIMATED MHSA EXPENDITURES FY 2017-18: $2,778,843

SERVICES FOR DEAF AND HARD OF HEARING

These services assist clients who are deaf and hard of hearing in achieving a more adaptive level of functioning and offer culturally and linguistically appropriate, specialized outpatient services for individuals who may have a co-occurring SUD. Interventions begin with an integrated biopsychosocial assessment and may include group or individual sessions, crisis intervention, and ongoing group services. Strength-based care plans include referrals to other community-based organizations. Services include a member-run clubhouse with six-month assessments of progress toward individual goals. The program provides dedicated staff for different age groups, including adults, older adults, TAY, and children who are deaf or hard of hearing and have SMI or SUD.

- *POPULATION:* All ages of individuals with SMI or SUD who are deaf or hard of hearing.
- *KEY OUTCOMES*: Functional stabilization or improvement, progress toward employment, educational and other individual goals, satisfaction with services, family participation, improve SUD issues, improve community involvement at discharge, and improve in SUD recovery knowledge and activities.
- *KEY MEASUREMENTS*: Successful discharge or transfer to primary care, California Substance Abuse Treatment Scale-Revised (SATS-R) survey, completion of client satisfaction survey, provider score on Dual Diagnosis Capability tool, and self-report at discharge.

SERVICES FOR VICTIMS OF TRAUMA AND TORTURE

Persons who have suffered trauma or torture are at risk of developing new or worsening behavioral symptoms. This program seeks to improve access to mental health services for victims of torture with SMI or SED. The outpatient services use the Milestones of Recovery Scale (MORS) and a trauma-informed perspective to avoid inadvertently re-traumatizing clients.

- *POPULATION:* All ages of uninsured, unserved individuals with SED and SMI who are victims of trauma and torture.
- *KEY OUTCOMES:* Increase access and use of mental health services, ensure culture-specific services, outreach and education to the target population, and appropriate referrals for trauma and torture victims who do not meet criteria of medical necessity.
- *KEY MEASUREMENTS*: Clinical and functional stabilization or improvement, improvement in SUD issues, MORS tool results, trauma-informed assessment tool, and adoption of the CLAS standards.

MENTAL HEALTH AND PRIMARY CARE SERVICES INTEGRATION

These programs strive to ensure mental health services are fully integrated with primary care. These programs ensure that primary care, pediatric, and obstetric providers have uniform access to psychiatric and addiction consultations. Services are delivered through the enhanced Screening, Brief Intervention and Referral to Treatment (SBIRT) model for adult patients. Programs provide identified individuals with behavioral health interventions based on screening and provide access to medications services when deemed medically necessary. Programs are designed for children, TAY, adults and older adults, for both Medi-Cal and uninsured patients.

- *POPULATION:* All ages.
- *KEY OUTCOMES*: Improve capacity to treat behavioral health conditions, improve identification of behavioral health issues, including suicide risk, participation in monthly family education groups, and increase provider satisfaction.
- *KEY MEASUREMENTS:* SBIRT tool, completion of a satisfaction survey, pre- and post-tests at required quarterly trainings, annual client focus groups, and telephonic follow-up.

ALL AGES – SYSTEM DEVELOPMENT (ALL-SD)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $4,324,698

PSYCHIATRIC EMERGENCY RESPONSE TEAM

Psychiatric Emergency Response Teams (PERT) partner clinicians with specially trained police officers and deputies to ensure a more effective response to interactions involving law enforcement officers and individuals with mental illness. Teams are on-call and provide countywide services to individuals with a mental health crisis who have come in contact with local law enforcement agencies and/or who need immediate mental health crisis intervention.

- *POPULATION:* All ages.
- *KEY OUTCOMES:* Reduce incarceration, reduce inappropriate hospitalizations, increase access to services, and enhance public safety services.
- *KEY MEASUREMENTS*: Monthly multi-disciplinary meetings, document and record incidents, including demographics, description of incident, action taken and outcomes, and monthly reporting of outcome objectives.

CHALDEAN AND MIDDLE EASTERN OUTPATIENT SERVICES

This program provides culturally appropriate mental health services for Chaldean, Iraqi refugee, and other Middle Eastern populations. Services provided include outpatient services for Chaldean and Middle Eastern communities, and case management and linkage to services for Iraqi refugees and other Middle Eastern populations. Additionally, children and youth with SED may receive outpatient clinical behavioral health services, as well as acculturation groups.

- *POPULATION*: Adults with SMI who may have a co-occurring SUD, and children and youth with SED.
- *KEY OUTCOMES*: Reduction in barriers for underserved population, increase in access and use of services, provision of culturally appropriate services, clinical and functional improvement or stabilization, improvement in SUD issues, and identification of domestic violence issues.
- *KEY MEASUREMENTS*: Regular collection and reporting of results from MORS tool and annual administration of the Mental Health Statistics Improvement Program survey.

CSS PROPOSED EXPENDITURE PLAN AND ESTIMATED COST PER CLIENT

The table below represents the estimated cost per client for FY 2017-18, 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 2017-18 Proposed Budget (All Funding)*	*FY 2015-16 Actual Cost Per Client*	*FY17/18 Estimated # Clients Served*
CY-FSP	Children, Youth	$42,162,982	$5,297	7,960
CY-OE	Children, Youth	$2,223,074	$1,734	1,282
CY-SD	Children, Youth	$18,436,469	$3,811	4,838
TAOA-FSP	Adults, TAY	$57,814,019	$10,103	5,722
TAOA-FSP	OA	$62,157,540	$1,012	61,420
TAOA-SD	TAY, Adults, OA	$1,245,036	$965	1,290
ALL-OE	ALL	$2,854,167	$1,980	1,441
ALL-SD	ALL	$7,063,448	$770	9,173
Total		**$193,956,734**	**-**	**-**

Assumptions:

- Figures are rounded to the nearest whole number.
- 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 2017-18 estimated cost per client figures are based on the total proposed FY 2017-18 budget divided by the actual cost per client from FY 2015-16, since that is the most recent full year of data available.
- The FY 2015-16 figures are derived from the estimated FY 2015-16 MHSA Revenue and Expenditure Report (RER) divided by the actual number of unique clients served for each work plan in that FY.
- The estimated average cost per client is a summary by work plan. Within each work plan the specific cost per client will vary by service and contract based on the contracted rate, type of service, and number of repeat clients.
- The annual projected unique clients for FY 2017-18 will vary from the number of unique clients served in Appendix D as some programs no longer exist and new programs will be added in FY 2017-18. Additionally, clients may receive one or more different services, so there may be duplication in clients across work plans.
- The TAOA-OE work plan was newly added in FY 2016-17.

PREVENTION AND EARLY INTERVENTION

Prevention and Early Intervention (PEI) programs bring mental health awareness into the lives of all members of the community through public education initiatives and dialogue. Aimed at unserved and underserved communities, prevention programs seek to reduce the risk factors for developing a potentially serious mental illness (SMI) and build on protective factors, strengths, and resiliency. To ensure access to appropriate support at the earliest point of emerging mental health issues, early intervention programs build capacity for providing mental health treatment 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.

New regulations, proposed by the Mental Health Services Oversight and Accountability Commission (MHSOAC) and adopted in the Welfare and Institutions Code (WIC) in October 2015, require additional information to be reported in the MHSA Three-Year Plan and subsequent Annual Updates for PEI programs. This new PEI program information includes identifying target populations to be served, the proposed number of persons to be served, key measurements, and outcomes. PEI programs also must be identified as supporting each of the key PEI service areas, including prevention, early intervention, outreach to increase recognition of the early signs of mental illness, stigma and discrimination reduction, suicide prevention, and access and linkage to treatment.

The County ensures that every provider of PEI services incorporates the following:

- *CULTURAL COMPETENCE:* PEI programs operated through community-based organizations have extensive cultural competency requirements included in the contract, which are closely monitored to ensure compliance.
- *MEASUREMENTS AND DATA COLLECTION*: Data for PEI programs are collected by the BHS Quality Improvement (QI) and Performance Improvement Team (PIT) systems to ensure outcomes are measured.
- *UNSERVED AND UNDERSERVED COMMUNITIES:* To ensure sufficient access and engagement for all persons, PEI programs must engage or focus on timely services to unserved and underserved communities. PEI programs may further define specific populations to serve based on the services provided. Programs require specific training and practices for providers to better understand unserved and underserved populations to assure adherence to evidence-based practices and standards in promoting access and engagement.

The following programs are grouped in the Expenditure Plan (Appendix A) by the work plan acronym in parentheses.

PREVENTION

ELDER MULTICULTURAL ACCESS AND SUPPORT SERVICES (OA-01)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $573,592

At the heart of Elder Multicultural Access and Support Services (EMASS) are Community Health Workers (CHWs), who are members of the communities they serve. CHWs are leaders in their social circle who are usually experienced in

dealing with friends or family members experiencing SMI. CWHs are trained by professionals in reaching and engaging older adults to support the prevention of mental illness. They interact with their peers through group and individual activities, including recreation and exercise, healthy aging and mental health education, and one-on-one counseling. Additional services include referral to multi-lingual mental health providers, transportation, and translation services for appointments with medical and mental health providers. EMASS supports and organizes CHWs in underserved San Diego County communities, such as those of Filipino, Latino, African refugee, African-American, and Middle Eastern descent. Services are integrated into community locations like senior housing, older adult day care centers, senior social centers, and faith-based community locations.

- *POPULATION:* Adults and older adults.
- *ESTIMATED NUMBER TO BE SERVED:* 950 individuals.
- *KEY OUTCOMES*: Reduce ethnic disparities, increase timely access to care, increase self-sufficiency, increase knowledge of the healthcare system, reduce isolation, increase socialization, reduce emergency room services, and reduce institutionalization.
- *KEY MEASUREMENTS*: Post-implementation data on the number of clients served, surveys and focus groups aggregating client self-reported outcomes on symptoms and literacy.

ALLIANCE FOR COMMUNITY EMPOWERMENT (DV-03)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $403,120

Exposure to violence may cause trauma that increases risk of mental illness in the younger population. Alliance for Community Empowerment (ACE) is a community response team that encircles siblings of identified gang members and seeks to bolster their resiliency and the resiliency of their family. Team members engage children and youth in schools, recreational centers, program offices, and individual homes. Parents are engaged and supported. Additionally, a mobile team responds to crises. Services provided through the ACE program include classes, activities, and grief counseling.

- *POPULATION:* Siblings of identified gang members or affiliates in Central San Diego, children of incarcerated parents and children exposed to household violence.
- *ESTIMATED NUMBER TO BE SERVED:* 511 children and youth.
- *KEY OUTCOMES:* Increase problem-solving skills and resilience, increase coping skills, increase positive attitudes and behaviors supportive of wellness and mental health, reduce stigma for seeking treatment or recovery services, and reduce suicidal risk factors.
- *KEY MEASUREMENTS*: Administer clinical pre- and post-tests targeting risk reduction, increase of parental knowledge and self-sufficiency, reduce psychosocial impact of trauma, completion of satisfaction surveys, and data collection, reporting, and assessment of results.

COMMUNITY SERVICES FOR FAMILIES (DV-04)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $503,908

Through a partnership with CWS, parents are identified to receive in-home training about risk factors for child neglect and physical abuse. The curriculum teaches parenting skills, including how to interact in a positive manner with their child, respond appropriately to challenging child behaviors, recognizing hazards in the home, and recognizing and responding to symptoms of illness and injury. The training, an evidence-based program known nationally as SafeCare, is conducted by CWS in cooperation with several community-based agencies through weekly in-home sessions.

- *POPULATION:* Families identified by CWS.
- *ESTIMATED NUMBER TO BE SERVED:* Number varies due to referrals from CWS.
- *KEY OUTCOMES:* Establish safe and supportive home life, timely reunification, support for children who are at risk of removal from their parent or caregiver's home, ability of children to remain safety in their home, and appropriate resource referrals.
- *KEY MEASUREMENTS*: Attendance at classes and family meetings, clinical assessment tools, complete care plan and achievement of goals, awareness and knowledge of services, data collection, comprehensive monthly outcome reports, completion of satisfaction surveys, and multidisciplinary team (MDT) case review.

DREAM WEAVER CONSORTIUM (NA-01)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $1,591,611

The Dream Weaver program consists of a partnership with four Indian health clinics that joins together cultural practices with evidence-based prevention concepts. It operates on reservations and in urban areas. Education and consultation are included at community events, cultural and social gatherings, and the health clinics. Intervention areas include suicide prevention, child abuse prevention, case management, SUD treatment and recovery services. Dream Weaver supports CHWs and Elder Navigators who engage youth and adults. Partners include the Indian Health Council, Inc., Southern Indian Health Council, Inc., San Diego American Indian Health Center, and the Sycuan Medical Dental Center.

- *POPULATION:* Native Americans, Alaska Natives, and qualified family members residing on reservations or in urban settings.
- *ESTIMATED NUMBER TO BE SERVED:* 6,528 individuals.
- *KEY OUTCOMES*: Increase awareness of eligibility for mental health services, increase awareness of American Indian/Alaska Native community wellness activities, increase knowledge of social, emotional and behavioral issues to prevent mental illness, involvement in child abuse prevention, reduce isolation, and enhance resilience.
- *KEY MEASUREMENTS*: Attendance at health fairs and events, satisfaction and awareness surveys, assessment instruments, data collection, regular reporting, and assessment of results.

PS-01 EDUCATION AND SUPPORT LINES

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $1,459,163

Education programs are offered in a variety of settings including community engagement by County of San Diego health promotion staff, technical consultant services for supported employment, Mental Health First Aid (MHFA), and Project Enable for adults in stressful situations. Workshops deal with practical issues such as job training or general mental health knowledge. Presentations by peers and clinicians are supported by pamphlets, which are available at groups, clubhouses and community gatherings. County staff and community-based agencies use evidence-based training, like MHFA, to equip citizens to recognize and respond effectively to emerging mental health needs of their families and neighborhoods. Specialized programs, such as Project Enable, target youth as they transition out of jail back into their community.

- *POPULATION:* Adults, older adults and TAY, and African-American and Latino TAY transitioning from jail.
- *ESTIMATED NUMBER TO BE SERVED:* 5,325 individuals (for MHFA and Project Enable).

- *KEY OUTCOMES*: Reduce family isolation and stigma associated with seeking behavioral health services, increase resiliency and protective factors for children, reduce parental stress, and improve school climate to help children thrive.
- *KEY MEASUREMENT*: Successful completion of courses tracked by population demographic and quarterly data collection and monitoring.

NEXT STEPS (CO-03)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $1,519,500

The Next Steps team is located at the San Diego County Psychiatric Hospital and engages individuals in the Crisis and Emergency units. Next Steps is a recovery-oriented, peer-and-family support program that focuses on whole health. Clinicians draw on their own lived experience to empower participants by modeling self-management, assisting in developing self-care skills, and linking to community resources. The team includes licensed mental health professionals and certified SUD counselors serving 15 designated mental health and SUD service sites. Services include care coordination, engagement, mental health service system navigation, and education of family members to support the participant's treatment.

- *POPULATION:* Adults and older adults.
- *ESTIMATED NUMBER TO BE SERVED:* 10,200 individuals.
- *KEY OUTCOMES:* Increase resiliency and self-care, reduce consumption of alcohol and drugs, admission into treatment (if needed), improve medication adherence, decrease depression and anxiety, reduce problems commonly associated with SUD, and improve participants' mental and physical wellness.
- *KEY MEASUREMENTS:* Decrease suicide risk (measured by County-approved tool), improvement self-rating on the PEI general survey, participation in WRAP, participation in support groups, reduction in use of and readmission to emergency and crisis units, enrollment family members in classes, evaluation of Recovery Marker Questionnaire (RMQ), Illness Management and Recovery (IMR) and other approved tools for alcohol and substance use levels, client, family and staff completion of satisfaction surveys, quarterly status reports on successful completion of objectives, and independent measurement of results and impact of the program.

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

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $1,108,580

Triple P is a skill-training class for parents with children in Head Start and Early Head Start centers, and in elementary school settings, who are exhibiting behavioral and/or emotional problems. Triple P is an evidence-based model used internationally. The classroom training aims to strengthen the skills of parents, child care staff, and educators to improve the development, growth, health, and social competency of children and youth. After program completion, families remain connected with opportunities for individual consultations for up to six months. Families requiring specialty mental health services are linked directly to services.

- *POPULATION:* Families identified by Head Start and Early Head Start.
- *ESTIMATED NUMBER TO BE SERVED:* 3,055 parents and families.
- *KEY OUTCOMES*: Develop and improve social competence of young children, reduce child abuse, mental illness, behavioral and emotional problems, delinquency and school failure, increase linkage of families to mental health and social services, reduce the prevalence of coercive or inappropriate parenting behaviors, and increase community awareness of positive parenting principles.

- *KEY MEASUREMENTS*: PEI surveys, completion of satisfaction surveys, data collection, submission of quarterly outcomes, and status reports.

POSITIVE SOLUTIONS (OA-02)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $583,073

Older adults who face limited mobility often become socially isolated, essentially 'locked up' in their own homes. Isolation frequently leads to mental illness and vulnerability to abuse. Positive Solutions reaches out to these adults and engages them with an evidence-based program known as Program to Encourage Active and Rewarding Lives (PEARLS). Services include short-term care management and crisis interventions.

- *POPULATION:* Homebound adults and older adults.
- *ESTIMATED NUMBER TO BE SERVED:* 880 individuals.
- *KEY OUTCOMES*: Increase social support and physical activities, reduce and/or resolve depressive symptoms, reduce substance abuse and/or medication abuse, increase and maintain individual self-sufficiency, increase coping skills, reduce suicide attempts, reduce or eliminate stigma of mental health issues and use of services, and client satisfaction.
- *KEY MEASUREMENTS:* Completion of a client satisfaction survey based on PEARLS objectives.

REACH 2, CAREGIVER SUPPORT FOR ALZHEIMER AND OTHER DEMENTIA CLIENTS SUPPORT SERVICES (OA-06)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $1,089,190

Caregivers of loved ones with Alzheimer's disease or other dementia conditions commonly fall prey to depression and stress. Resources for Enhancing Alzheimer's Caregiver Health (REACH) is a nationally recognized model to relieve the burden of caregiving. REACH clinicians guide caregivers through four-session trainings that include six-month follow-up phone consultations. Multiple studies using validated instruments to measure symptoms have shown effective outcomes. Services include linkage with resources and problem solving.

- *POPULATION*: Family caregivers of persons with Alzheimer's or other dementia conditions.
- *ESTIMATED NUMBER TO BE SERVED:* 8,100 individuals.
- *KEY OUTCOMES*: Decrease symptoms of depression, improve overall quality of life, increase self-care, increase caregiving abilities, and decrease feelings of anger and stress.
- *KEY MEASUREMENTS*: Depression inventory, caregiver stress and burden scale, client completion of a satisfaction survey, institutional placement, compliance with REACH guidelines for operations of an evidence-based program, and monthly submission of PEI Report, program status and mental health status data.

SCHOOL-BASED PROGRAM (SA-01)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $6,231,858

The school-based prevention programs combine the Incredible Years curriculum with CHWs who are parent leaders trained to act as liaisons with children, teachers, staff, and other parents. The training curriculum promotes social and emotional learning, emotion regulation, and problem solving through classroom lessons, afterschool groups, and parenting groups. Parents and family members learn skills to improve their parent-child relationships, as well as build a support system by getting to know other parents within the community. Partners include a variety of community-based agencies and school districts. Schools that serve a refugee population are enhanced to offer specialized

programing that recognizes and addresses the linguistic and cultural needs of the students and families with a careful consideration for issues of trauma and acculturation needs.

- *POPULATION:* Referrals from teachers, school staff and parents of children attending one of the participating elementary schools, and a focus on underserved Latino and Asian/Pacific Islander communities.
- *ESTIMATED NUMBER TO BE SERVED:* 17,653 students.
- *KEY OUTCOMES:* Reduce family isolation and stigma associated with seeking behavioral health services, increase resiliency and protective factors for children, assess and reduce parental stress, and improve school climate for children to thrive.
- *KEY MEASUREMENTS:* Ability of parents to demonstrate empathy and knowledge of child's needs through non-verbal and verbal signals, Parent Stress Index/Short Form, and monthly data collection and monitoring to ensure program conforms to evidence-based practice guidelines.

EARLY INTERVENTION

CO-OCCURRING DISORDER SCREENING BY COMMUNITY-BASED SUD PROVIDERS (CO-02)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $5,250,483

More than two dozen SUD treatment and recovery programs in San Diego County have an integrated co-occurring disorder component. Individuals entering SUD treatment and recovery are screened for co-occurring mental health disorders in this Early Intervention program. At each location, program participants are encouraged to receive screening and initial counseling with licensed clinicians, who review symptoms and behavioral issues. The SUD program may link individuals with specialized care within their organization or with community service partners. The screenings are client-centered and aim to reduce stigma associated with mental health concerns.

- *POPULATION:* Youth and adults in integrated SUD treatment and recovery programs.
- *ESTIMATED NUMBER TO BE SERVED:* 10,582 individuals.
- *KEY OUTCOMES*: Early detection and treatment of SED or SMI, increase access and use of mental health services, and improve participants' mental and physical wellness.
- *KEY MEASUREMENTS*: Decrease suicide risk (measured by County-approved tool), improve self-rating on the PEI general survey, participate in WRAP, participate in support groups, reduce use of and readmission to emergency and crisis units, enroll family members in classes, client, family and staff completion of satisfaction surveys, quarterly reports on successful completion of objectives, and independent measurement of results and impact of the program.

KICKSTART (FB-01)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $1,788,845

Kickstart identifies, trains, and empowers community leaders, known as Gatekeepers, to detect indicators of early psychosis. Gatekeepers refer teens and young adults with potential mental health and/or SUD issues, or that have experienced trauma and abuse, to clinicians who provide screening and assessment. Services include intensive psychosocial and treatment intervention, crisis intervention, individual and group psychoeducation, multi-family groups, in-home services, and other support. Individuals needing help for SED or SMI are transitioned to outpatient mental health programs.

- *POPULATION*: Youth (ages 10-17) and TAY (ages 18-25).
- *ESTIMATED NUMBER TO BE SERVED:* 1,250 individuals.
- *KEY OUTCOMES:* Reduce negative effects of SED and SMI, early identification of untreated mental health issues, early detection of at-risk behaviors, increase well-being leading to reduced hospitalizations and diversion from incarceration, increase school success and family involvement, reduce stigma in seeking mental health services, appropriate referrals, decrease early symptoms of SED and SMI, improve functioning, and decrease SUD.
- *KEY MEASUREMENTS:* Structured Interview for Prodromal Symptoms (SIPS) instrument, pre- and post-testing and surveys at 6, 12, and 18-months post discharge, measurement tools and data collection, and submission of monthly and annual outcome reports.

RURAL INTEGRATED BEHAVIORAL HEALTH AND PRIMARY CARE / SMART CARE (RC-01)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $1,438,881

Behavioral health specialists operate alongside nurses and doctors in small rural clinics throughout San Diego County's backcountry. Educators provide mental health information for patients and refer them to comprehensive services available through the clinics and by phone. Services include screening, evaluation, education, and short-term counseling. This program also includes prevention services.

- *POPULATION:* Rural residents and patients at participating community clinics.
- *ESTIMATED NUMBER TO BE SERVED:* 900 individuals.
- *KEY OUTCOMES:* Early detection and treatment of SMI, and increase access and use of mental health services.
- *KEY MEASUREMENTS:* Improved or stabilized SBIRT assessment scores, quantity of drug prescriptions, provision of appropriate services, patient satisfaction, awareness and knowledge, clinical staff satisfaction, data collection, monthly and annual submission of outcome results of clinical interventions and satisfaction.

OUTREACH

INDEPENDENT LIVING ASSOCIATION (RE-01)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $302,340

Independent living facilities are privately-owned homes or complexes that provide housing for adults with mental illness and other disabling health conditions. They serve residents who do not need medication oversight, are able to function without supervision, and live independently. Members of the Independent Living Association (ILA) include owners, operators and community-based organizations who advocate for quality housing. The ILA manages an online directory of ILA members that maintain stakeholder-determined quality standards. The group also provides education and training for residents, operators, and the community.

- *POPULATION:* ILA membership is open to all.
- *ESTIMATED NUMBER TO BE SERVED:* 61 active facility members (does not include residents).
- *KEY OUTCOMES:* Maintain a public website and directory, publication of and adherence to quality standards created by ILA for members' facility operations.
- *KEY MEASUREMENTS:* Participation of members and leadership in monthly meetings, monitor updates of directory, members' adherence to standards, and data from monthly reports.

STIGMA AND DISCRIMINATION REDUCTION

BREAKING DOWN BARRIERS (PS-01)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $437,800

Breaking Down Barriers is an outreach campaign that engages five distinct, underserved communities, including Latino, African-American, Native American, African immigrants/refugees, and Lesbian, Gay, Bisexual, Transgendered and Questioning (LGBTQ) individuals, to increase access to mental health services. The campaign's Cultural Broker strategy builds community acceptance through organized group presentations, individual one-to-one resource sharing and conversation, and participation at community events, fairs, or celebrations. Cultural Brokers serve as mediators between groups or persons of different cultural backgrounds to bridge understanding. Cultural brokering is an ancient practice traced to the earliest recorded encounters between cultures.

- *POPULATION:* Latino, African-American, Native American, African and LGBTQ communities.
- *ESTIMATED NUMBER TO BE SERVED:* Not applicable.
- *KEY OUTCOMES:* Reduce stigma and discrimination, increase awareness and acceptance of mental illness and treatment choices, increase access and use of available services, especially in previously unserved and underserved communities, and develop a knowledge base for best practices of outreach and engagement.
- *KEY MEASUREMENTS*: Post-meeting surveys to detect resource awareness, knowledge, and satisfaction, feedback from communities on ongoing strategies, input of Cultural Brokers, data collection, and submission of quarterly and annual reports in each targeted community.

FATHER2CHILD (PS-01)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $250,000

The Father2Child program offers 12-week classes focused on improving attitudes toward fathering, parenting skills and knowledge. As a mental health stigma reduction effort, the program staff target fathers through outreach, engagement, and education. Classes are based on a best practice model created by the National Fatherhood Initiative. The program supports work-readiness by providing interview attire, job-related clothing, and specific tools necessary for various jobs. Job-readiness helps establish financial stability for the benefit of his children and family.

- *POPULATION:* Custodial and non-custodial fathers of children living in the central San Diego City area.
- *ESTIMATED NUMBER TO BE SERVED:* Fathers representing a minimum of 200 children.
- *KEY OUTCOMES:* Reduce stigma and discrimination, increase awareness and acceptance of mental illness and treatment choices, and increase access and use of available services, especially in unserved and underserved communities.
- *KEY MEASUREMENTS:* Annual program self-evaluation with Cultural Competency certification tools, client survey of self-identified awareness of available resources, and agency report on partnership effectiveness.

IT'S UP TO US CAMPAIGN (UP2US) (PS-01)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $2,274,033

It's Up to Us is a countywide media campaign that promotes understanding and awareness of the stigma associated with mental illness, greater individual acceptance of mental illness, and the choices for intervention, treatment, and recovery. It is an evidence-based social marketing approach (Alan, R. Andreasen, 1995) that reaches into the daily lives of San Diegans through television, radio, and billboards targeting cultural, ethnic, and social groups. The campaign seeks to empower first responders, hospital, and clinic providers to provide practical and relevant tools targeting stigma. Social media outlets, including Facebook, Twitter, and Pinterest are key platforms in the strategy. Pamphlets, flyers, and brochures are distributed at hundreds of local events and public venues, including libraries, waiting rooms, and offices.

- *POPULATION*: All residents of San Diego County.
- *ESTIMATED NUMBER TO BE SERVED:* Approximately 3,300,000 (residents living in San Diego County).
- *KEY OUTCOMES*: Reduce stigma and discrimination, increase awareness and acceptance of mental illness and treatment choices, and increase access and use of available services, especially in unserved and underserved communities.
- *KEY MEASUREMENTS*: Data collection through regular updates for each element of multi-media campaign, including all materials and websites in each targeted language and population centers monitored by County staff.

EDUCATION AND SUPPORT LINES (PS-01)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $198,560

The Friends in Our Lobby and In Our Own Voice programs provide specialized services by individuals who have a lived mental health experience or are a caregiver or family member of an individual who has experienced mental illness. Through Friends in the Lobby, trained volunteers provide outreach and engage individuals visiting their loved ones in local hospitals. They also provide support and valuable information. In Our Own Voice trains community speakers to share their personal stories about living with mental illness and achieving recovery. Presentations are scheduled by request at various venues. The programs aim to reduce stigma about mental illness and improve hope for recovery.

- *POPULATION:* Adults and older adults with lived experience and caregivers or family members of individuals who are at-risk of or experiencing behavioral health issues.
- *ESTIMATED NUMBER TO BE SERVED:* 1,500 individuals and/or their families.
- *KEY OUTCOMES*: 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.
- *KEY MEASUREMENTS*: Data collection through regular reports, annual report outlining the needs of adults and older adults, and caregivers and family members, including recommendations to evaluate system responsiveness.

SUICIDE PREVENTION

HELPING, ENGAGING, RECONNECTING, EDUCATING (HERE) NOW PROJECT (SA-02)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $1,814,040

The HERE Now project is a school-based suicide prevention program that reaches middle and high school age students through education, outreach, screening, and referrals. School staff and families are also educated about suicide prevention, including brief intervention, conversation, and referrals. In addition, the program attempts to reach students in non-school settings where students may be more willing to participate. Parents participate in educational classes held on school campuses. The program tracks achievement of goals by reviewing California Healthy Kids Survey data collected among students at school sites where the program is implemented.

- *POPULATION*: Middle and high school age students, school staff, parents, and guardians.
- *ESTIMATED NUMBER TO BE SERVED*: 17,635 students.
- *KEY OUTCOMES*: Increase knowledge of risk, resilience and protective factors, increase identification of students at risk for suicide, improve well-being, increase school connectedness, reduce stigma, improve access, improve problem-solving skills and willingness to seek help, and increase number of trained responders in the community.
- *KEY MEASUREMENTS:* Change behaviors and attitudes as measured by evidence-based tools, CA Healthy Kids and PEI surveys, referrals to mental health services, participation in education programs, and complete provider cultural competency certification.

SUICIDE PREVENTION COUNCIL (PS-01)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $500,000

The Suicide Prevention Council is a collaboration of community groups, service providers, residents, and other stakeholders who seek to establish an action plan to increase understanding and awareness of suicide risks and warning signs, and implement strategic initiatives. The Council recruits non-traditional partners to take active roles in organizing activities, creating education materials for community dissemination, media advocacy, and helping serve as a community voice on suicide prevention. The Council also helps train individuals and groups about early identification, referral, and intervention of suicide, including how to provide follow-up care to someone contemplating suicide. The programming and planning by the Council has a special focus of reaching and impacting LBGTQ, TAY, Veterans, and older adults.

- *POPULATION*: All residents of San Diego County, with additional focus on LBGTQ, TAY, Veterans and older adults.
- *ESTIMATED NUMBER TO BE SERVED:* Approximately 3,300,000 (residents living in San Diego County.
- *KEY OUTCOMES:* Increase collaboration among stakeholders, service providers and mental health professionals, provide trainings to increase awareness and capacity among residents to help prevent suicide, increase awareness of suicide prevention, enhance and expand resources for LBGTQ and TAY, and improve data collection and evaluation to support effective programs.
- *KEY MEASUREMENTS:* Qualitative assessment through regular collaboration and participant meetings, adherence to best practice community-practice models, data collection and submission of monthly reports on outcomes.

ACCESS AND LINKAGE TO TREATMENT

COURAGE TO CALL (VF-01)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $1,007,800

Courage to Call provides a dedicated helpline for individuals in the military community seeking information and resources. The peer operated phone line and internet chat room are staffed by Veterans and are a part of the extensive www.211sandiego.org information system. The program conducts outreach at military-friendly community events and collaborative organizations.

- *POPULATION:* Veterans, active duty military, reservists, National Guard members, and military service family members.
- *ESTIMATED NUMBER TO BE SERVED:* 1,000 individuals.
- *KEY OUTCOMES*: Increase awareness of the prevalence of mental illness in the military community, reduce mental health risk factors or stressors, improve access to mental health information and support, increase access and linkage to services, increase understanding of mental illness, and improve access to preventive, intervention, and treatment services.
- *KEY MEASUREMENTS*: Successful linkage of clients, culturally competent staff, data collection, and monthly reports on outcomes.

STATEWIDE PREVENTION AND EARLY INTERVENTION PROGRAMS

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $522,883

The California Mental Health Service Authority (CalMHSA) is a Joint Powers Authority that was created by counties in 2010 to administer statewide MHSA PEI projects. CalMHSA is in Phase II of the statewide plan to encourage prevention and early intervention of behavioral health issues through a focused media campaign. Phase III of the plan will focus on the implementation of social marketing campaigns and related programs, with an emphasis on reaching Latino communities. Phase III is projected to require additional funding, therefore, CalMHSA is proposing to allocate funding for a consulting firm to raise private funds. On October 13, 2016, the CalMHSA Board approved a special member fee for all member counties to support these efforts. The proposed allocation for San Diego County is 4% of the overall cost of the consultant firm, a sum proportional to its population relative to other member counties.

The County of San Diego's membership in CalMHSA has supported efforts such as maintaining and expanding social marketing campaigns, creating new outreach materials for diverse audiences, providing technical assistance and outreach to counties, schools, and local community-based organizations, providing stigma reduction trainings to diverse audiences, and building the capacities of higher education schools to address stigma reduction and suicide prevention.

OUTCOMES OF CALMHSA STATEWIDE PEI PROGRAMS IN SAN DIEGO COUNTY FOR FY 2015-16:

- More than 22,000 related campaign materials, including Each Mind Matters, Walk in Our Shoes, Directing Change, and Know the Signs were disseminated across San Diego County.
- 32 local agencies, schools and organizations received outreach materials, training, technical assistance, or presentations about stigma reduction and suicide prevention.
- Six Walk in Our Shoes performances were conducted reaching 1,106 students.

- 535 faculty, staff, and students from eight community colleges in San Diego County participated in outreach events and online mental health and suicide prevention trainings.
- 14 film submissions from local high schools and colleges were posted online for the Directing Change campaign.
- Mental Health Awareness Week outreach materials were distributed to over 17,000 County staff.

PEI Proposed Expenditure Plan and Estimated Cost Per Client

The table below represents the estimated cost per client for FY 2017-18, 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 Work Plan	*Population Served*	*FY 2017-18 Proposed Budget (All Funding)*	*FY 2015-16 Actual Cost Per Client*	*FY 2017-18 Estimated # Clients Served*
CO-02 Co-Occurring Disorders	ALL	$8,978,736	$848	10,582
CO-03 Next Steps	ALL	$2,519,500	$247	10,200
DV-03 Alliance for Community Empowerment	Children, Youth	$403,120	$789	511
DV-04 Point of Engagement	Children, Youth	$503,908	NA	NA
EC-01 Positive Parenting Program	Children, Youth	$1,108,580	$363	3,055
FB-01 Kick Start	Children, TAY	$1,788,845	$1,431	1,250
NA-01 Dream Weaver	ALL	$1,758,611	$269	6,528
OA-01 Elder Multicultural Access & Support Services (EMASS)	OA	$573,592	$604	950
OA-02 Positive Solutions	OA	$583,073	$663	880
OA-06 Caregiver Support	Adults, OA	$1,089,190	$134	8,100
PS-01 Education and Support Lines	ALL	$5,367,837	$2	3,307,025
RC-01 SmartCare	ALL	$1,438,881	$1,599	900
RE-01 Independent Living Association	TAY, Adults, OA	$302,340	NA	NA
SA-01 School Based Program	Children, Youth	$6,231,858	$353	17,653
SA-02 Here Now	Children, Youth, TAY	$1,814,040	$103	17,635
VF-01 Courage to Call	ALL	$1,007,800	$1,008	1,000
Total		**$35,469,912**	**-**	**-**

Assumptions:

- Figures are rounded up to the nearest whole number.
- 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.
- Data for the following programs is not included:
  - DV-04: Point of Engagement Programs - Embedded within Child Welfare Services (CWS) (varies based on referrals)
  - PS-01: Community Health Promotion Specialists and Supported Employment Technical Consultant (varies annually)
  - RE-01: Independent Living Association (does not provide direct service to clients but rather ILA facilities)
- The FY 2017-18 estimated cost per client figures are based on the total proposed FY 2017-18 budget divided by the actual cost per client from FY 2015-16, since FY 2015-16 is the most recent full year of data available.
- The FY 2015-16 figures are derived from the estimated FY 2015-16 MHSA Revenue and Expenditure Report (RER) divided by the actual number of unique clients served for each work plan.
- The estimated average cost per client is a summary by work plan. Within each work plan the specific cost per client will vary by service and contract based on the contracted rate, level of service and number of repeat clients.
- The annual projected unique clients for FY 2017-18 will vary from the number of unique clients served in Appendix G as some programs no longer exist and new programs will be added in FY 2017-18. Additionally, clients may receive one or more different services, so there may be duplication in clients across work plans.

INNOVATION

Innovation (INN) programs are defined as novel, creative, and/or ingenious mental health practices and approaches. The programs are short term, expected to contribute to learning, and are developed with community input through a process that is inclusive and representative, especially of unserved and underserved individuals. INN funds allow counties the opportunity to try new approaches that can inform current and future mental health practices and approaches.

On April 25, 2017, the County of San Diego Board of Supervisors (BOS) approved the extension and/or expansion of five Cycle 3 programs, first approved in 2015 and currently in operation, and the addition of five new programs for Cycle 4. Three of the new proposals, INN-20 Roaming Outpatient Access Mobile (ROAM) Services, INN-21 Recuperative Services Treatment (ReST) Recuperative Housing, and INN-22 Medication Clinic, were approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) on May 25, 2017. The remaining new proposals and extensions and/or expansions of current programs are still pending approval from the MHSOAC.

The programs below are grouped in the Expenditure Plan (Appendix A) by the work plan acronym in parentheses. Detailed narratives for the new INN programs and the proposed enhancements/extensions to current INN programs are located in Appendix I and J.

EVALUATION

Innovation programs require data analysis and evaluation services to assess client and system outcome measures. To meet this requirement, all INN programs have evaluation funds embedded within their budgets that are used for separate evaluation services provided by UCSD.

A detailed annual report with evaluation results is provided in Appendix I.

CYCLE 3 PROGRAMS

FAITH-BASED PROGRAMS (INN-13)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $819,588

This program is designed to collaborate and partner with faith-based organizations to address underserved populations. These services promote collaboration between BHS and faith-based leaders to provide cross-education and information on services provided in the community to reduce the effects of untreated mental illness. The educational curriculum provides information and training on faith/spirituality principles and values, wellness, and mental health conditions to the African-American and Latino communities in the North Inland and Central Regions.

- *POPULATION*: Mental Health professionals and clergy (in the North Inland and Central Regions).
- *KEY OUTCOMES*: Increase community engagement and collaboration.
- *KEY MEASUREMENTS*: Participation in meetings and activities, pre- and- post- tests of participant knowledge, stakeholder feedback, and reduction of recidivism rates.

RAMP UP 2 WORK (INN-14)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $1,239,244

This project engages and retains employment opportunities through an enhanced array of supported and competitive employment options. The program promotes self-determination and empowerment and helps clients overcome barriers to employment.

- *POPULATION:* TAY, adults and older adults with SMI.
- *KEY OUTCOMES*: Increase opportunities for employment, increase ability to maintain employment and increase opportunities for self-employment.
- *KEY MEASUREMENTS*: Annual reports of connections with employment opportunities, participation and progress of participants.

CYCLE 3 PROPOSED EXTENSIONS AND/OR EXPANSIONS

Caregiver Connection (INN-11) - Expansion - PENDING APPROVAL FROM THE MHSOAC

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $614,653

This program supports parents and caregivers of children aged 0-5 in clinical settings. Care coordinators address the caregivers' own behavioral health needs through direct care and comprehensive referral. The BOS approved expanding services to parents and caregivers of latency (aged 6-11) and adolescent-age children, and extending the current contract for an additional 1.5 years.

- *POPULATION*: Parents and/or caregivers of children receiving specialty mental health outpatient services, who have been identified as experiencing behavioral health issues and/or caregiver stress.
- *KEY OUTCOMES*: Increase resilience, promote recovery and wellness for caregivers, increase access to services, and stabilize and sustain wellness.
- *KEY MEASUREMENTS*: Pre-and-post- test of participants, participation records and service usage.

FAMILY THERAPY PARTICIPATION (INN-12) - EXPANSION - PENDING APPROVAL FROM THE MHSOAC

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $1,852,277

In clinical settings, the program trains parent partners to increase participation in family therapy. Partners emphasize the benefit of active engagement in the treatment process and addressing barriers on an individual basis. The BOS approved expanding services to an additional six locations, one in each service delivery region, and extending current contracts for an additional 1.5 years.

- *POPULATION:* Children and TAY up to age 21 with a focus on unserved and underserved populations, including Latinos and African-Americans.
- *KEY OUTCOMES:* Increase participation in family therapy and increase access to services.
- *KEY MEASUREMENTS*: Participate in family therapy sessions, pre- and post-tests of participants, and quarterly status reports.

PEER ASSISTED TRANSITIONS (INN-15) - EXPANSION - PENDING APPROVAL FROM THE MHSOAC

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $1,693,181

This project employs Peer Specialist Coaches (PSCs) serving adults diagnosed with SMI to promote engagement through peer support, use of Welcome Home Backpacks, social and recreational activities, and to help them connect with relevant services. PSCs engage the client in an inpatient setting, such as a crisis house, and assist with planned discharge and transition back to the community. The BOS approved expanding the program to a third crisis house and extending the current contract for one additional year.

- *POPULATION*: Adults with SMI.
- *KEY OUTCOMES:* Increase self-sufficiency, decrease individual crisis episodes, and increase access to support services.
- *KEY MEASUREMENTS:* Annual report on hospitalizations, hospitalization days, crisis house admissions, linkage to formal supports, support network participation, self-report of recovery, and client input of progress.

URBAN BEATS (INN-16) - EXPANSION - PENDING APPROVAL FROM THE MHSOAC

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $645,390

This program is designed to increase engagement and access to treatment, reduce stigma, enhance cultural expression, and provide strength-based messages to the TAY population. Participating TAY are enrolled in 20-week academies designed to focus on engagement and artistic exploration through the visual arts, spoken word, videos and performances. The BOS approved expanding services to the North Central Region, adding East African and transportation services, and extending the current contract for one additional year.

- *POPULATION:* TAY experiencing or at risk of SMI.
- *KEY OUTCOMES:* Participate in activities, engagement, stabilization and improvement in symptoms.
- *KEY MEASUREMENTS:* Monthly evaluation of participation rates, self-rating scores, observer ratings, measurable outcomes, and possibly school functioning reports.

COGNITIVE REHABILITATION AND EXPOSURE/SORTING THERAPY (CREST) MOBILE HOARDING UNITS (INN-17) - EXPANSION – PENDING APPROVAL FROM THE MHSOAC

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $721,060

This program, previously referred to as Innovative Mobile Hoarding Intervention Program (IMHIP), seeks to diminish long term hoarding behaviors in older adults by combining an adapted cognitive-rehabilitation therapy with hands-on training and support. The team consists of specially-trained professionals and peers who also collaborate with participants' health providers. An aftercare support group helps participants maintain the skills learned. The BOS approved expanding services to the South Region and extending the current contract for an additional 1.5 years.

- *POPULATION:* Uninsured, Medi-Cal, and Medicare beneficiaries ages 60+ who meet medical necessity criteria for psychiatric conditions.
- *KEY OUTCOMES*: Reduce hoarding behaviors, reduce anxiety and depression, increase engagement and functioning, and provide access to services.
- *KEY MEASUREMENTS:* Pre-and-post-test on clutter and hoarding scales, participation in an aftercare group, and linkage to follow-up care.

CYCLE 4 NEW PROGRAM PROPOSALS

PERIPARTUM SERVICES (INN-18) - PENDING APPROVAL FROM THE MHSOAC

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $0 *(PROGRAM STARTS IN FY 2018-19)*

This program will partner with Public Health Nurses to screen parents from unserved or underserved populations for perinatal mood and anxiety disorders and, when needed, provide them with treatment and linkages to appropriate resources and care. The goal is to decrease negative consequences from untreated behavioral health issues.

- *POPULATION:* Pregnant women and their partners and parents with young children who have been screened and identified as needing mental health services.
- *KEY OUTCOMES:* Reduce barriers to service and symptomatology, and increase engagement, awareness, and usage of services.
- *KEY MEASUREMENTS*: Client participation and engagement, linkage to services, and self-reporting of progress toward goals.

TELEMENTAL HEALTH (INN-19) - PENDING APPROVAL FROM THE MHSOAC

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $0 *(PROGRAM STARTS IN FY 2018-19)*

This program will introduce Telemental Health to youth and adults who experience barriers to connecting with behavioral health services following psychiatric hospitalization. Telemental Health is the use of technology and software to provide therapeutic outpatient services. The goal is to decrease recidivism and increase the effectiveness of follow-up engagement and treatment.

- *POPULATION:* Children, TAY and adults who have experienced a psychiatric emergency, are unconnected to outpatient services and are at risk of recidivism.
- *KEY OUTCOMES*: Reduce recidivism, hospitalizations, use of crisis services, and participate in follow-up services and engagement.
- *KEY MEASUREMENTS:* Service usage, engage in follow-up process, and regular reports of clinical outcomes.

ROAMING OUTPATIENT ACCESS MOBILE (ROAM) SERVICES (INN-20) - APPROVED BY THE MHSOAC

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $1,426,243

This program will deploy two mobile mental health clinics to San Diego County's rural Native American communities in the East and North Inland Regions of San Diego. The goal is to provide comprehensive and culturally competent behavioral health services on Native American reservations. The program will improve access and utilization of mental health services by addressing geographic and cultural barriers through the use of mobile mental health clinics and cultural brokers.

- *POPULATION:* Native American youth, families, adults, and older adults living on reservations in rural areas.
- *KEY OUTCOMES:* Increase access and utilization of clinic services and decrease stigma.
- *KEY MEASUREMENTS:* Annual reports of clinic outcomes, client surveys, and community feedback.

RECUPERATIVE SERVICES TREATMENT (REST) HOUSING (INN-21) - APPROVED BY THE MHSOAC

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $700,140

This program will adapt the medical field's recuperative housing model by increasing engagement services for unconnected TAY who are homeless or at risk of homelessness after being discharged from acute emergency mental health care. The goal is to prevent future admissions to acute emergency settings by providing short-term (up to 90 days) comprehensive, on-site services to link clients to permanent housing, appropriate ongoing mental health services, and other needed resources.

- *POPULATION*: Homeless and unconnected TAY (aged 18-25) with SMI.
- *KEY OUTCOMES:* Reduce recidivism, increase access to services, stabilize and improve clinical and functional outcomes.
- *KEY MEASUREMENTS:* TAY who transition to stable housing and report of clinical outcomes.

MEDICATION CLINIC (INN-22) - APPROVED BY THE MHSOAC

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $0 *(PROGRAM STARTS IN FY 2018-19)*

This program will provide psychotropic medication support for children and youth who have stabilized clinically but require complex medication management. The goal is to support function, safety, and reduce suffering so children and youth can participate in school, community activities, and in a rich home life.

- *POPULATION*: Children and youth:
    - With SED who are stable and have completed their psychotherapy treatment services;
    - Who are new to the region, awaiting entry into outpatient programs and are already taking psychotropic medications; and
    - Who are currently being treated for complex medical problems and have SED but have no access to a child and adolescent psychiatrist.
- *KEY OUTCOMES:* Stabilization of medication management.
- *KEY MEASUREMENTS:* Regular clinical reports of outcomes and family and staff completion of satisfaction surveys.

INN PROPOSED EXPENDITURE PLAN & ESTIMATED COST PER CLIENT

The table below represents the estimated cost per client for FY 2017-18, 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 Work Plan	*Population Served*	*FY 2017-18 Proposed Budget (All Funding)*	*FY 2017-18 Estimated # Clients Served*	*FY 2017-18 Estimated Cost Per Client*
INN-11 Caregiver Connection	Children, Youth, TAY (up to 21)	$614,653	300	$2,049
INN-12 Family Therapy Participation	Children (ages 0-5)	$2,072,854	960	$2,159
INN-13 Faith Based Initiative	ALL	$ 819,588	220	$3,725
INN-14 Ramp Up to Work	TAY, Adults, OA	$1,239,244	105	$11,802
INN-15 Peer Assisted Transitions	TAY, Adults, OA	$1,693,181	300	$5,644
INN-16 Urban Beats	TAY	$645,390	800	$807
INN-17 Cognitive Rehabilitation and Exposure/Sorting Therapy (CREST) Mobile Hoarding Units	OA	$721,060	50	$14,421
INN-18 Peripartum Services	TAY, Adults	-	-	$0
INN-19 Telemental Health	ALL	-	-	$0
INN-20 Roaming Outpatient Access Mobile (ROAM) Services	ALL	$1,426,243	140	$10,187
INN-21 Recuperative Services Treatment (ReST) Recuperative Housing	TAY (ages 18-25)	$700,140	60	$11,669
INN-22 Medication Clinic	Children, Youth	-	-	$0
Total		**$9,932,354**	**-**	**-**

Assumptions:

- Figures are rounded up to the nearest whole number.
- 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 2017-18 estimated cost per client figures are based on the total proposed FY 2017-18 budget divided by the estimated proposed number of clients to be served in FY 2017-18, based on estimates from the programs.
- The estimated average cost per client is a summary by work plan.
- The annual projected unique clients for FY 2017-18 will vary from the number of unique clients served in Appendix I as some programs are new and will be added in FY 2017-18.

WORKFORCE EDUCATION AND TRAINING

Workforce Education and Training (WET) programs are intended to assist with the shortage of qualified individuals within the public mental health workforce who provide services to persons with mental illnesses by providing support through education and training. WET carries forth the vision of the MHSA to create a transformed, culturally-competent system that promotes wellness and recovery for adults and older adults with SMI, resiliency for children and youth with SED, and their families.

Strategies include recruitment of high school and community college students for mental health occupations, development of curricula to increase knowledge and skills of the existing workforce, promotion of the meaningful employment of consumers and their family members in the mental health system, and financial incentives that promote cultural and linguistic diversity in the public mental health workforce. Programs are intended to incorporate cultural competency in all training and education programs, increase mental health career development opportunities, expand post-secondary education capacity, expand loan repayment scholarship programs, create stipend programs, promote distance learning techniques, and promote meaningful inclusion of client and family members in all training and education programs.

WET funds were received as a one-time allocation to be spent by June 30, 2018. The balance of WET funds has steadily decreased so the County has opted to transfer $2.9 million of CSS funds in FY 2017-18 to the MHSA WET component to continue funding programs. The need for additional WET funds will be evaluated annually.

The initial WET plan for San Diego County was completed in 2009 using an extensive needs assessment and multiple stakeholder input processes. The WET plan for FY 2017-18 through FY 2019-20 reflects a continuation of the original plan as reflected below.

The programs below are grouped in the Expenditure Plan (Appendix A) by the work plan acronym in parentheses.

WET-02 TRAINING AND TECHNICAL ASSISTANCE

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $1,719,587

BEHAVIORAL HEALTH EDUCATION AND TRAINING ACADEMY (BHETA)

BHETA implements and evaluates a behavioral health training curriculum for system-wide training for the County of San Diego. The curriculum provides awareness, knowledge, and skill based trainings for behavioral health staff. Trainings address the needs for all levels of staff in BHS programs and organizations and these training are provided in a variety of modalities to include classrooms, eLearnings, and webinars. The goal of these trainings is to provide behavioral health staff with the knowledge and skills to be better able to outreach, assess, and support the recovery of adults and children suffering from mental illness and support their families. BHETA also provides workforce development services, such as staffing needs assessments, career path analyses, and staff development. The BHETA program is funded through a contract with the San Diego State University Research Foundation.

- *POPULATION:* County and contracted mental health staff.
- *KEY OUTCOMES:* Increase competency in a number of areas, including cultural understanding, co-occurring disorders, family centered services, and resiliency.
- *KEY MEASUREMENTS:* Number of trainings provided and number of attendees for each training.

REGIONAL TRAINING CENTER

The Regional Training Center provides training, conferences, and consultants to BHS and contracted provider staff. Programs include Training and Technical Assistance, the Big Why Conference, the We Can't Wait Annual Conference, and Incredible Years Training.

- *POPULATION:* County and contracted mental health staff.
- *KEY OUTCOMES:* Improve the competency and diversity of the workforce to better meet the needs of the populations receiving services, satisfaction with quality and accessibility of the training, increase competency and capacity for prevention and early intervention, reduce stigma through increased workforce awareness, and increase access to underserved populations.
- *KEY MEASUREMENTS:* Number of trainings and conferences provided and number of attendees for each training and conference.

WET-03 MENTAL HEALTH CAREER PATHWAY PROGRAMS

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $307,485

PUBLIC MENTAL HEALTH ACADEMY – ACADEMIC COUNSELOR

This program is a collaborative, community-based public mental health certificate program. The certificate assists individuals with educational qualifications for current and future mental health employment opportunities and creates options for individuals to enroll into higher education programs to assist in the career pathway continuum.

- *POPULATION:* Latinos, Asian/Pacific Islanders, and LGBTQ individuals in or recently out of foster care, and other populations defined by County staff and the community.
- *KEY OUTCOMES:* Increase mental health service providers, increase linguistic and cultural competence through knowledge and awareness of policies, procedures and practices to meet State and County requirements, reduce stigma through workforce awareness, and increase access to underserved populations.
- *KEY MEASUREMENTS:* Students success in completion of the Public Mental Health Academy.

CONSUMER AND FAMILY ACADEMY – PEER SPECIALIST TRAINING

This program provides recovery-oriented, Peer Specialist training for adults to prepare them to work in the County of San Diego's public behavioral health system. The training and participants' personal recovery experience prepares them to work as partners in practice, program, and policy fields.

- *POPULATION*: Adult, parent, TAY and family member peer support specialists.
- *KEY OUTCOMES:* Increase client-centered services and increase the benefits of behavioral health services.
- *KEY MEASUREMENTS:* Number of individuals with lived experience of behavioral health challenges and recovery processes provided with evidence based peer specialist training and number of classes provided to BHS provider direct service staff and management.

WET-04 RESIDENCY AND INTERNSHIP PROGRAM

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $957,410

COMMUNITY PSYCHIATRY RESIDENCY TRAINING

Through a contract with the University of California San Diego (UCSD) Community Psychiatry Program, BHS provides training and clinical supervision in community psychiatry for psychiatry residents and psychiatric nurse practitioner trainees. This program fosters the development of leaders in community psychiatry by providing medical students, general psychiatry residents, and psychiatric nurse practitioner trainees with instruction on the principles of community psychiatry, including exposure to the unique challenges and opportunities within this field. The Residency Training Track has the goal of further enhancing interest in working within the public behavioral health system, a sector that has experienced a severe personnel shortage for a number of years.

- *POPULATION*: Physicians interested in psychiatry.
- *KEY OUTCOMES*: Advance the concepts of community psychiatry, train additional psychiatrists, encourage them to take leadership roles in community psychiatry, and provide stable funding for training.
- *KEY MEASUREMENTS:* Psychiatry residents are successfully recruited and trained in the community psychiatry track, and psychiatric mental health nurse practitioner trainees are successfully recruited and trained in partnership with nursing programs in San Diego County.

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS

Capital Facilities and Technological Needs (CFTN) funding is used for capital projects and technological capacity to improve mental illness service delivery by expanding opportunities for accessible community-based services for clients and their families. CFTN funds also promote reduction in disparities in underserved groups. CFTN funds are one-time funds that must be spent by June 30, 2018 and the balance has steadily decreased. In FY 2016-17 and FY 2017-18, CSS funds may be transferred to complete capital CF projects.

Capital Facility 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 County's 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 that is culturally and linguistically competent. The programs also modernize and transform clinical and administrative information systems to ensure quality of care, operational efficiency, and cost effectiveness.

The programs below are grouped in the Expenditure Plan (Appendix A) by the work plan acronym in parentheses.

CAPITAL FACILITIES (CF)

CF-2 North Coastal Mental Health Center

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $979,290

BHS will finish construction of the Mental Health Center in the North Coastal Region. The facility, co-located with Public Health Services (PHS), houses a mental health clinic and clubhouse program, and increases accessibility for persons living in North County. The CF funds proportionally fund the MHSA services provided within the facility.

- *POPULATION*: Adults and older adults in North Coastal Region.
- *KEY OUTCOMES:* Increase accessibility to behavioral health services.

CF-4 North Inland Crisis Residential Facility

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $706,727

BHS was awarded a California Health Facility Financing Authority (CHFFA) grant to build the North Inland Crisis Residential facility, a short-term crisis residential facility with 15 beds for adults with SMI and co-occurring disorders. The new facility was built, licensed, and operational in 2016. BHS will allocate additional funds this project.

- *POPULATION*: Adults and older adults in the northern regions of San Diego County.
- *KEY OUTCOMES*: Increase accessibility to crisis residential services.

CF-5 Children's Emergency Screening Unit (ESU) in Hillcrest

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $700,000

BHS established a crisis stabilization facility in a central location within San Diego County to enhance services for children and youth. The relocated ESU expands capacity by increasing from 4 to 12 crisis stabilization beds. The centralized location of the new facility allows for enhanced accessibility from any area of San Diego County and is scheduled to open in late fall 2017.

- *POPULATION:* Children and youth.
- *KEY OUTCOMES:* Increase access to crisis stabilization services.

TECHNOLOGICAL NEEDS (TN)

SD-03 Personal Health Record - Patient Portal (CCBH Annual Fees)

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $100,500

The County's current Management Information System, Cerner Community Behavioral Health (CCBH) is an electronic health record and billing application used by County staff and contracted providers to coordinate client care, perform required State reporting requirements, and bill Medi-Cal and other payers. The County is working to establish a patient portal within CCBH. This Personal Health Record module allows clients the ability to view their health information via a portal providing ease of access and a means of speedy communication with their provider.

SD-5 Telemedicine

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $170,396

Telemedicine provides video, secure email, and phone consultation to improve accessibility of care in underserved and rural areas. It helps maintain technological infrastructure for the mental health system to ensure high-quality, cost-effective services, and supports for clients and their families. Systems are provided to community-based providers in clinical outpatient, residential, and school-based settings in dozens of different locations.

SD-6 MH MIS Expansion - 6.0 FTEs for Road Map into Millennium Process

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $500,000

The current application for the electronic health record for mental health services, CCBH, will sunset by the year 2024. BHS will begin the initial planning and roadmap into the upgraded product, Millennium, beginning in FY 2017-18. A transition team of approximately six subject matter experts will provide support and project management to ensure a successful transition from CCBH to Millennium.

SD-8 Data Exchange - Connect Well San Diego Interoperability

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $4,800,000

This project will aggregate data across the continuum of care from disparate systems, creating a comprehensive patient record containing information that supports programs such as decision support, quality measurement, and analytics for population management. The ConnectWellSD platform will be developed to create a Health Information Exchange (HIE) to provide the means for this interoperability project. Funds will be used to implement the Curam

application. Interoperability is necessary in order to share data across the continuum of care and provide person-centered care.

SD-9 Financial Management System

ESTIMATED MHSA EXPENDITURES IN FY 2017-18: $1,171,240

The Financial Management System will ensure operational efficiency and cost effectiveness in mental health administration by creating a centralized financial system capable of day-to-day budget management, year-to-date revenue and expenditure monitoring, financial information for contracts, and business analytics tools, including standard reports, dashboards, and queries. This system will streamline financial data collection and reporting, such as assisting with the annual MHSA Revenue and Expenditure Report (RER), maintain the integrity of data with system securities, and prevent duplication of effort to ensure resources are fully maximized.

APPENDICES

A: MHSA PROGRAM AND EXPENDITURE SUMMARY

B: CERTIFICATIONS AND MINUTE ORDER

C: PROGRAM SUMMARIES

D: FULL SERVICE PARTNERSHIPS (FSP) OUTCOMES REPORT

E: FSP ASSERTIVE COMMUNITY TREATMENT (ACT) WITH MHSA HOUSING FUNDS REPORT

F: COMMUNITY SERVICES AND SUPPORTS (CSS) FY 2015-16 ANNUAL REPORT

G: PREVENTION AND EARLY INTERVENTION SYSTEMWIDE SUMMARY

H: 2016 COMMUNITY ENGAGEMENT REPORT

I: INNOVATION EVALUATION AND PROPOSALS – CYCLE 3

J: INNOVATION PROPOSALS – CYCLE 4

K: BHS FY 2016-17 STRATEGIC HOUSING UPDATE

L: MHSA ISSUE RESOLUTION PROCESS

M: MHSA AND CRIMINAL JUSTICE CLIENTS FY 2017-18

N: COUNTY OF SAN DIEGO DEMOGRAPHICS

O: GLOSSARY OF ACRONYMS

P: MHSA STAKEHOLDER FEEDBACK

Appendix A

MHSA Program and Expenditure Summary

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: San Diego

Date: **6/30/17**

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2017/18 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	82,156,338	8,816,902	21,136,109	409,592	10,497,376	
2. Estimated New FY2017/18 Funding*	114,900,000	30,640,000	7,660,000			
3. Transfer in FY2017/18[a/]	(2,900,000)			2,900,000		
4. Access Local Prudent Reserve in FY2017/18						
5. Estimated Available Funding for FY2017/18	194,156,338	39,456,902	28,796,109	3,309,592	10,497,376	0
B. Estimated FY17/18 MHSA Expenditures	**$ 137,475,041**	**$ 35,398,218**	**$ 11,168,543**	**$ 2,984,483**	**$ 10,497,376**	
C. Estimated FY2018/19 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	56,681,297	4,058,684	17,627,566	325,109	(0)	0
2. Estimated New FY2018/19 Funding*	113,100,000	30,160,000	7,540,000			
3. Transfer in FY2018/19[a/]	(3,200,000)			3,200,000		
4. Access Local Prudent Reserve in FY2018/19						
5. Estimated Available Funding for FY2018/19	166,581,297	34,218,684	25,167,566	3,525,109	(0)	0
D. Estimated FY2018/19 Expenditures	**$ 136,822,442**	**$ 31,923,785**	**$ 15,731,162**	**$ 3,291,710**	**$ -**	
E. Estimated FY2019/20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	29,758,855	2,294,899	9,436,404	233,399	(0)	0
2. Estimated New FY2019/20 Funding*	112,800,000	30,080,000	7,520,000			
3. Transfer in FY2019/20[a/]	(3,300,000)			3,300,000		
4. Access Local Prudent Reserve in FY2019/20						
5. Estimated Available Funding for FY2019/20	139,258,855	32,374,899	16,956,404	3,533,399	(0)	0
F. Estimated FY2019/20 Expenditures	**$ 136,822,442**	**$ 31,923,785**	**$ 12,099,668**	**$ 3,296,741**	**$ -**	
G. Estimated FY2019/20 Unspent Fund Balance	**2,436,412**	**$ 451,115**	**$ 4,856,736**	**$ 236,659**	**$ (0)**	

* Estimated new funding from State consultant estimates in April 2017

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2017	$ 42,193,120
2. Contributions to the Local Prudent Reserve in FY 2017/18	0
3. Distributions from the Local Prudent Reserve in FY 2017/18	0
4. Estimated Local Prudent Reserve Balance on June 30, 2018	$ 42,193,120
5. Contributions to the Local Prudent Reserve in FY 2018/19	0
6. Distributions from the Local Prudent Reserve in FY 2018/19	0
7. Estimated Local Prudent Reserve Balance on June 30, 2019	$ 42,193,120
8. Contributions to the Local Prudent Reserve in FY 2019/20	0
9. Distributions from the Local Prudent Reserve in FY 2019/20	0
10. Estimated Local Prudent Reserve Balance on June 30, 2020	$ 42,193,120

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

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County San Diego Date: 6/30/17

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CY-FSP Full Service Partnerships for Children & Youth	$ 42,162,982	28,622,970	8,808,652		4,731,359	
2. TAOA-FSP Full Service Partnerships for Ages 18-65+	$ 57,814,019	38,125,304	17,464,656		2,224,059	
3.	$ -					
4.	$ -					
5.	$ -					
6.	$ -					
7.	$ -					
8.	$ -					
9.	$ -					
10.	$ -					
11.	$ -					
12.	$ -					
Non-FSP Programs						
1. ALL-OE Outreach & Engagement for All Ages	$ 2,854,167	2,778,843	75,324			
2. ALL-SD System Development for All Ages	$ 7,063,448	4,324,698	152,950		2,585,800	
3. CY-OE Outreach & Engagement for Children & Youth	$ 2,223,074	1,884,300	338,774			
4. CY-SD System Development for Children & Youth	$ 18,436,469	10,244,948	1,489,118		6,702,403	
5. TAOA-OE Outreach & Engagement for Ages 18-65+	$ 1,245,036	750,876	-		494,160	
6. TAOA-SD System Development for Ages 18-65+	$ 62,157,540	32,811,575	17,813,110		11,532,855	
7.	$ -					
8.	$ -					
9.	$ -					
10.	$ -					
11.	$ -					
12.	$ -					
CSS Administration	$ 17,931,527	$ 17,931,527				
CSS MHSA Housing Program Assigned Funds	$ -	$ -	$ -	$ -	$ -	$ -
Total CSS Program Estimated Expenditures	$ 211,888,261	$ 137,475,041	$ 46,142,584	$ -	$ 28,270,636	$ -
FSP Programs as Percent of Total	72.7%					

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County San Diego Date: 6/30/17

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CY-FSP Full Service Partnerships for Children & Youth	$ 42,162,982	28,622,970	8,808,652		4,731,359	
2. TAOA-FSP Full Service Partnerships for Ages 18-65+	$ 57,814,019	38,125,304	17,464,656		2,224,059	
3.	$ -					
4.	$ -					
5.	$ -					
6.	$ -					
7.	$ -					
8.	$ -					
9.	$ -					
10.	$ -					
11.	$ -					
12.	$ -					
Non-FSP Programs						
1. ALL-OE Outreach & Engagement for All Ages	$ 2,854,167	2,778,843	75,324			
2. ALL-SD System Development for All Ages	$ 7,063,448	4,324,698	152,950		2,585,800	
3. CY-OE Outreach & Engagement for Children & Youth	$ 2,223,074	1,884,300	338,774			
4. CY-SD System Development for Children & Youth	$ 17,907,374	9,830,255	1,534,716		6,542,403	
5. TAOA-OE Outreach & Engagement for Ages 18-65+	$ 1,245,036	750,876	-		494,160	
6. TAOA-SD System Development for Ages 18-65+	$ 62,004,755	32,658,790	17,813,110		11,532,855	
7.	$ -					
8.	$ -					
9.	$ -					
10.	$ -					
11.	$ -					
12.	$ -					
CSS Administration	$ 17,846,406	$ 17,846,406				
CSS MHSA Housing Program Assigned Funds	$ -	$ -				
Total CSS Program Estimated Expenditures	$ 211,121,261	$ 136,822,442	$ 46,188,182	$ -	$ 28,110,636	$ -
FSP Programs as Percent of Total	73.1%					

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County San Diego Date: 6/30/17

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CY-FSP Full Service Partnerships for Children & Youth	$ 42,162,982	28,622,970	8,808,652		4,731,359	
2. TAOA-FSP Full Service Partnerships for Ages 18-65+	$ 57,814,019	38,125,304	17,464,656		2,224,059	
3.	$ -					
4.	$ -					
5.	$ -					
6.	$ -					
7.	$ -					
8.	$ -					
9.	$ -					
10.	$ -					
11.	$ -					
12.	$ -					
Non-FSP Programs						
1. ALL-OE Outreach & Engagement for All Ages	$ 2,854,167	2,778,843	75,324	-		-
2. ALL-SD System Development for All Ages	$ 7,063,448	4,324,698	152,950	-	2,585,800	-
3. CY-OE Outreach & Engagement for Children & Youth	$ 2,223,074	1,884,300	338,774	-		-
4. CY-SD System Development for Children & Youth	$ 17,907,374	9,830,255	1,534,716		6,542,403	-
5. TAOA-OE Outreach & Engagement for Ages 18-65+	$ 1,245,036	750,876	-	-	494,160	-
6. TAOA-SD System Development for Ages 18-65+	$ 62,004,755	32,658,790	17,813,110		11,532,855	
7.	$ -					
8.	$ -					
9.	$ -					
10.	$ -					
11.	$ -					
12.	$ -					
CSS Administration	$ 17,846,406	$ 17,846,406				
CSS MHSA Housing Program Assigned Funds	$ -	$ -				
Total CSS Program Estimated Expenditures	$ 211,121,261	$ 136,822,442	$ 46,188,182	$ -	$ 28,110,636	$ -
FSP Programs as Percent of Total	73.1%					

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: San Diego Date: 6/30/17

	Fiscal Year 2017/18						
	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-02 Co-Occuring Disorders	$ 8,978,736	5,250,483	203,000		3,525,253		EI
2. CO-03 Integrated Peer & Family Engagement - Next Steps	$ 2,519,500	1,519,500			1,000,000		P
3. DV-03 Alliance for Community Empowerment	$ 403,120	403,120					P
4. DV-04 Point of Engagement	$ 503,908	503,908					P
5. EC-01 Positive Parenting Program	$ 1,108,580	1,108,580					P
6. FB-01 Kick Start	$ 1,788,845	1,788,845					EI
7. NA-01 Dream Weaver	$ 1,758,611	1,591,611			167,000		P
8. OA-01 Elder Multicultural Access & Support Services	$ 573,592	573,592					P
9. OA-02 Positive Solutions	$ 583,073	583,073					P
10. OA-06 Positive Solutions	$ 1,089,190	1,089,190					P
11. PS-01 Education and Support Lines	$ 5,367,837	5,119,556			248,281		P / S&D / SP
12. RC-01 SmartCare	$ 1,438,881	1,438,881					P / EI
13. RE-01	$ 302,340	302,340					O
14. SA-01 School Based Program	$ 6,231,858	6,231,858					P
15. SA-02 Here Now	$ 1,814,040	1,814,040					P
16. VF-01 Courage to Call	$ 1,007,800	1,007,800					A
17.	$ -						
18.	$ -						
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	$ 4,548,957	$ 4,548,957					
PEI Assigned Funds	$ 522,883	$ 522,883					
Total PEI Program Estimated Expenditures	$ 40,541,752	$ 35,398,218	$ 203,000	$ -	$ 4,940,534	$ -	

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: San Diego Date: 6/30/17

	Fiscal Year 2018/19						
	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-02 Co-Occuring Disorders	$ 4,723,086	2,683,918	203,000		1,836,168		EI
2. CO-03 Integrated Peer & Family Engagement - Next Steps	$ 2,519,500	1,519,500			1,000,000		P
3. DV-03 Alliance for Community Empowerment	$ 403,120	403,120					P
4. DV-04 Point of Engagement	$ 503,908	503,908					P
5. EC-01 Positive Parenting Program	$ 1,108,580	1,108,580					P
6. FB-01 Kick Start	$ 1,788,845	1,788,845					EI
7. NA-01 Dream Weaver	$ 1,758,611	1,591,611			167,000		P
8. OA-01 Elder Multicultural Access & Support Services	$ 573,592	573,592					P
9. OA-02 Positive Solutions	$ 583,073	583,073					P
10. OA-06 Positive Solutions	$ 1,089,190	1,089,190					P
11. PS-01 Education and Support Lines	$ 5,367,837	5,119,556			248,281		P / S&D / SP
12. RC-01 SmartCare	$ 1,438,881	1,438,881					P / EI
13. RE-01	$ 302,340	302,340					O
14. SA-01 School Based Program	$ 6,231,858	6,231,858					P
15. SA-02 Here Now	$ 1,814,040	1,814,040					P
16. VF-01 Courage to Call	$ 1,007,800	1,007,800					A
17.	$ -						
18.	$ -						
	$ -						
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	$ 4,163,972	$ 4,163,972					
PEI Assigned Funds	$ -	$ -					
Total PEI Program Estimated Expenditures	$ 35,378,234	$ 31,923,785	$ 203,000	$ -	$ 3,251,449	$ -	

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: San Diego Date: 6/30/17

	Fiscal Year 2019/20						
	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-02 Co-Occuring Disorders	$ 4,723,086	2,683,918	203,000		1,836,168		EI
2. CO-03 Integrated Peer & Family Engagement - Next Steps	$ 2,519,500	1,519,500			1,000,000		P
3. DV-03 Alliance for Community Empowerment	$ 403,120	403,120					P
4. DV-04 Point of Engagement	$ 503,908	503,908					P
5. EC-01 Positive Parenting Program	$ 1,108,580	1,108,580					P
6. FB-01 Kick Start	$ 1,788,845	1,788,845					EI
7. NA-01 Dream Weaver	$ 1,758,611	1,591,611			167,000		P
8. OA-01 Elder Multicultural Access & Support Services	$ 573,592	573,592					P
9. OA-02 Positive Solutions	$ 583,073	583,073					P
10. OA-06 Positive Solutions	$ 1,089,190	1,089,190					P
11. PS-01 Education and Support Lines	$ 5,367,837	5,119,556			248,281		P / S&D / SP
12. RC-01 SmartCare	$ 1,438,881	1,438,881					P / EI
13. RE-01	$ 302,340	302,340					O
14. SA-01 School Based Program	$ 6,231,858	6,231,858					P
15. SA-02 Here Now	$ 1,814,040	1,814,040					P
16. VF-01 Courage to Call	$ 1,007,800	1,007,800					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	$ 4,163,972	$ 4,163,972					
PEI Assigned Funds	$ -						
Total PEI Program Estimated Expenditures	$ 35,378,234	$ 31,923,785	$ 203,000	$ -	$ 3,251,449	$ -	

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: San Diego

	Fiscal Year 2017/18					
	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 3)						
1. INN-11 Caregiver Connection	$ 614,653	614,653				
2. INN-12 Family Therapy Participation	$ 2,072,854	1,852,277	220,577			
3. INN-13 Faith Based Initiative	$ 819,588	819,588				
4. INN-14 Ramp Up to Work	$ 1,239,244	1,239,244				
5. INN-15 Peer Assisted Transitions	$ 1,693,181	1,693,181				
6. INN-16 Urban Beats	$ 645,390	645,390				
7. INN-17 Cognitive Rehabilitation and Exposure/Sorting Therapy (CREST) Mobile Hoarding Units	$ 721,060	721,060				
INN Programs (Cycle 4)						
8. INN-18 Peripartum Services	$ -	-				
9. INN-19 Telemental Health	$ -	-				
10. INN-20 Roaming Outpatient Access Mobile (ROAM) Services	$ 1,426,243	1,426,243				
11. INN-21 Recuperative Services Treatment (ReST) Recuperative Housing	$ 700,140	700,140				
12. INN-22 Medication Clinic	$ -	-				
* Up to 5% for evaluation is embedded in Estimated INN Funding Awaiting MHSOAC Approval on Cycle 3 enhancements and Cycle 4 programs						
INN Administration	$ 1,456,767	$ 1,456,767				
Total INN Program Estimated Expenditures	$ 11,389,120	$ 11,168,543	$ 220,577	$ -	$ -	$ -

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: San Diego

	Fiscal Year 2018/19					
	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 3)						
1. INN-11 Caregiver Connection	$ 687,189	687,189				
2. INN-12 Family Therapy Participation	$ 2,249,670	2,029,093	220,577			
3. INN-13 Faith Based Initiative	$ 759,116	759,116				
4. INN-14 Ramp Up to Work	$ -	-				
5. INN-15 Peer Assisted Transitions	$ 1,801,325	1,801,325				
6. INN-16 Urban Beats	$ 690,371	690,371				
7. INN-17 Cognitive Rehabilitation and Exposure/Sorting Therapy (CREST) Mobile Hoarding Units	$ 772,696	772,696				
INN Programs (Cycle 4)						
8. INN-18 Peripartum Services	$ 503,900	503,900				
9. INN-19 Telemental Health	$ 1,171,352	1,171,352				
10. INN-20 Roaming Outpatient Access Mobile (ROAM) Services	$ 1,884,997	1,884,997				
11. INN-21 Recuperative Services Treatment (ReST) Recuperative Housing	$ 1,400,279	1,400,279				
12. INN-22 Medication Clinic	$ 1,978,952	1,978,952				
* Up to 5% for evaluation is embedded in Estimated INN Funding Awaiting MHSOAC Approval on Cycle 3 enhancements & Cycle 4 programs						
INN Administration	$ 2,051,891	$ 2,051,891				
Total INN Program Estimated Expenditures	$ 15,951,739	$ 15,731,162	$ 220,577	$ -	$ -	$ -

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: San Diego

	Fiscal Year 2019/20					
	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 3)						
1. INN-11 Caregiver Connection	$ 341,765	341,765				
2. INN-12 Family Therapy Participation	$ 1,113,877	893,300	220,577			
3. INN-13 Faith Based Initiative	$ -	-				
4. INN-14 Ramp Up to Work	$ -	-				
5. INN-15 Peer Assisted Transitions	$ 1,801,325	1,801,325				
6. INN-16 Urban Beats	$ -	-				
7. INN-17 Cognitive Rehabilitation and Exposure/Sorting Therapy (CREST) Mobile Hoarding Units	$ 721,945	721,945				
INN Programs (Cycle 4)						
8. INN-18 Peripartum Services	$ 503,900	503,900				
9. INN-19 Telemental Health	$ 994,987	994,987				
10. INN-20 Roaming Outpatient Access Mobile (ROAM) Services	$ 1,884,997	1,884,997				
11. INN-21 Recuperative Services Treatment (ReST) Recuperative Housing	$ 1,400,279	1,400,279				
12. INN-22 Medication Clinic	$ 1,978,952	1,978,952				
* Up to 5% for evaluation is embedded in Estimated INN Funding Awaiting MHSOAC Approval on Cycle 3 enhancements & Cycle 4 programs						
INN Administration	$ 1,578,218	$ 1,578,218				
Total INN Program Estimated Expenditures	$ 12,320,245	$ 12,099,668	$ 220,577	$ -	$ -	$ -

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: San Diego Date: 6/30/17

	Fiscal Year 2017/18					
	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	$ 1,719,587	1,719,587				
2. WET-03 Mental Health Career Pathway Programs	$ 307,485	307,485				
3. WET-04 Residency and Internship Program	$ 957,410	957,410				
4.	$ -					
5.	$ -					
6.	$ -					
7.	$ -					
8.	$ -					
9.	$ -					
10.	$ -					
11.	$ -					
12.	$ -					
13.	$ -					
14.	$ -					
15.	$ -					
16.	$ -					
WET Administration	$ -	$ -	$ -	$ -	$ -	$ -
Total WET Program Estimated Expenditures	$ 2,984,483	$ 2,984,483	$ -	$ -	$ -	$ -

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: San Diego Date: 6/30/17

	Fiscal Year 2018/19					
	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	$ 1,719,587	1,719,587				
2. WET-03 Mental Health Career Pathway Programs	$ 312,372	312,372				
3. WET-04 Residency and Internship Program	$ 1,259,750	1,259,750				
4.	$ -					
5.	$ -					
6.	$ -					
7.	$ -					
8.	$ -					
9.	$ -					
10.	$ -					
11.	$ -					
12.	$ -					
13.	$ -					
14.	$ -					
15.	$ -					
16.	$ -					
WET Administration	$ -	$ -	$ -	$ -	$ -	$ -
Total WET Program Estimated Expenditures	$ 3,291,710	$ 3,291,710	$ -	$ -	$ -	$ -

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: San Diego Date: 6/30/17

	Fiscal Year 2019/20					
	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	$ 1,719,587	1,719,587				
2. WET-03 Mental Health Career Pathway Programs	$ 317,403	317,403				
3. WET-04 Residency and Internship Program	$ 1,259,750	1,259,750				
4.	$ -					
5.	$ -					
6.	$ -					
7.	$ -					
8.	$ -					
9.	$ -					
10.	$ -					
11.	$ -					
12.	$ -					
13.	$ -					
14.	$ -					
15.	$ -					
16.	$ -					
WET Administration	$ -	$ -	$ -	$ -	$ -	$ -
Total WET Program Estimated Expenditures	$ 3,296,741	$ 3,296,741	$ -	$ -	$ -	$ -

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: San Diego

	Fiscal Year 2017/18					
	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	$ 979,290	979,290				
2. CF-4 North Inland Crisis Residential Facility	$ 706,727	706,727				
3. CF-5 Emergency Screening Unit (ESU) Facility	$ 700,000	700,000				
CFTN Programs - Technological Needs Projects						
1. SD-3 Personal Health Record	$ 100,500	100,500				
2. SD-5 Telemedicine Expansion	$ 170,396	170,396				
3. SD-6 MH MIS Expansion	$ 500,000	500,000				
4. SD-8 Data Exchange	$ 4,800,000	4,800,000				
5. SD-9 Financial Management System	$ 1,171,240	1,171,240				
All remaining CF/TN funds are projected to be spent by 6/30/18						
CFTN Administration	$ 1,369,223	$ 1,369,223				
Total CFTN Program Estimated Expenditures	$ 10,497,376	$ 10,497,376	$ -	$ -	$ -	$ -

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: San Diego

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	$ -	-				
2.	$ -	-				
3.	$ -	-				
4.	$ -					
5.	$ -					
CFTN Programs - Technological Needs Projects						
1.	$ -					
2.	$ -					
3.	$ -					
4.	$ -					
5.	$ -					
CFTN Administration	$ -	$ -				
Total CFTN Program Estimated Expenditures	$ -	$ -	$ -	$ -	$ -	$ -
There are $0 budgeted under Capital Facilities and Technological Needs in this fiscal year.						

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: San Diego

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	$ -	-				
2.	$ -	-				
3.	$ -	-				
4.	$ -					
5.	$ -					
CFTN Programs - Technological Needs Projects						
1.	$ -					
2.	$ -					
3.	$ -					
4.	$ -					
5.	$ -					
CFTN Administration	$ -	$ -				
Total CFTN Program Estimated Expenditures	$ -	$ -	$ -	$ -	$ -	$ -
There are $0 budgeted under Capital Facilities and Technological Needs in this fiscal year.						

Appendix B

Certifications and Minute Order

MHSA COUNTY COMPLIANCE CERTIFICATION

The signed Compliance Certificate will be inserted when the MHSA Three-Year Plan is adopted by the County of San Diego Board of Supervisors.

County/City: **San Diego**

☒ Three-Year Program and Expenditure Plan

☐ Annual Update

Local Mental Health Director	**Program Lead**
Name: **Alfredo Aguirre**	Name: **Adrienne Yancey**
Telephone Number: **(619) 261-4386**	Telephone Number: **(619) 584-5075**
E-mail: Alfredo.Aguirre@sdcounty.ca.gov	E-mail: Adrienne.Yancey@sdcounty.ca.gov
Local Mental Health Mailing Address: Health and Human Services Agency Behavioral Health Services Division 3255 Camino Del Rio South San Diego, CA 92108	

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three-Year Program and Expenditure Plan or Annual Update, including stakeholder participation and nonsupplantation requirements.

This Three-Year Program and Expenditure Plan or 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 Three-Year Program and Expenditure Plan or 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 _____, 2017.

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.

Alfredo Aguirre
Local Mental Health Director (PRINT)

Signature

Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

The signed Fiscal Accountability Certificate will be inserted when the MHSA Three-Year Plan is adopted by the County of San Diego Board of Supervisors.

County/City: **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: **Alfredo Aguirre** Telephone Number: **(619) 261-4386** E-mail: Alfredo.Aguirre@sdcounty.ca.gov	Name: **Tracy Sandoval** Telephone Number: **(619) 531-5413** E-mail: Tracy.Sandoval@sdcounty.ca.gov
Local Mental Health Mailing Address: Health and Human Services Agency Behavioral Health Services Division 3255 Camino Del Rio South 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.

Alfredo Aguirre
Local Mental Health Director (PRINT)

_____
Signature

_____
Date

I hereby certify that for the fiscal year ended June 30, 20__, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated_____for the fiscal year ended June 30, 20__. I further certify that for the fiscal year ended June 30, 20__, 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.

_____
County Auditor Controller / City Financial Officer (PRINT)

_____
Signature

_____
Date

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

COUNTY OF SAN DIEGO
BOARD OF SUPERVISORS
TUESDAY, _____, 2017

MINUTE ORDER NO. x

The signed Minute Order will be inserted when the MHSA Three-Year Plan is adopted by the County of San Diego Board of Supervisors.

SUBJECT: COUNTY OF SAN DIEGO MHSA THREE-YEAR PROGRAM AND EXPENDITURE PLAN: FISCAL YEARS 2017-18 THROUGH 2019-20 (DISTRICTS: ALL)

OVERVIEW:

FISCAL IMPACT:
BUSINESS IMPACT STATEMENT:

RECOMMENDATION:
CHIEF ADMINISTRATIVE OFFICER

ACTION:

State of California) County of San Diego) §

Minutes of the Board of Supervisors.
Clerk of the Board of Supervisors

Appendix C

Program Summaries

Program Summaries Work Plan Key

Community Sevices and Support (CSS)

Acronym	Work Plan Name
ALL-OE	Outreach & Engagement for All Ages
ALL-SD	System Development for All Ages
CY-FSP	Full Service Partnerships for Children & Youth
CY-OE	Outreach & Engagement for Children & Youth
CY-SD	System Development for Children and Youth
TAOA-FSP	Full Service Partnerships for Ages 18-65+
TAOA-OE	Outreach & Engagement for Ages 18-65+
TAOA-SD	System Development for Ages 18-65+

Prevention and Early Intervention (PEI)

Acronym	Work Plan Name
CO-02	Co-Occuring Disorders
CO-03	Integrated Peer & Family Engagement - Next Steps
DV-03	Alliance for Community Empowerment
DV-04	Point of Engagement
EC-01	Postive Parenting Program
FB-01	Kick Start
NA-01	Dream Weaver
OA-01	Elder Multicultural Access & Support Services
OA-02	Positive Solutions
OA-06	Postive Solutions
PS-01	Education and Support Lines
RC-01	SmartCare
RE-01	
SA-01	School Based Program
SA-02	Here Now
VF-01	Courage to Call

Innovation (INN)

Acronym	Work Plan Name
INN-11	Caregiver Connection
INN-12	Family Therapy Participation
INN-13	Faith Based Initiative
INN-14	Ramp Up to Work
INN-15	Peer Assisted Transitions
INN-16	Urban Beats
INN-17	Cognitive Rehabilitation and Exporsure/Sorting Therapy (CREST) Mobile Hoarding Units
INN-18	Peripartum Services
INN-19	Telemental Health
INN-20	Roaming Outpatient Access Mobile (ROAM) Services
INN-21	Recurperative Services Treatment (ReST) Recuperative Housing
INN-22	Medication Clinic

Program Summaries Work Plan Key

Workforce, Education and Training (WET)

Acronym	Work Plan Name
WET-02	Training & Technical Assistance
WET-03	Mental Health Career Pathway Programs
WET-04	Residency and Internship Program

Capital Facilities/Technological Needs (CFTN)

Acronym	Woprk Plan Name
CF-2	North County Mental Health Facility
CF-4	North Inland Crisis Residential Facility
CF-5	Emergency Screnning Unit (ESU) Facility
SD-3	Personal Health Record
SD-5	Telemedicine Expansion
SD-6	MH MIS Expansion
SD-8	Data Exchange
SD-9	Financial Management System

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
ALL-SD	Chaldean and Middle-Eastern Social Services	Outpatient mental health clinic providing 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	Individuals who are 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 S. Magnolia Ave. Suite 201 El Cajon, CA 92020 (619) 631-7400	All
ALL-OE	Deaf Community Services	Adult outpatient mental health clinic provides video, secure email, and phone consultation in a mental health walk-in outpatient clinic within the County of San Diego	Assist clients who are deaf and hard of hearing to achieve a more adaptive level of functioning	Children, 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
ALL-OE	Deaf Community Services Clubhouse	Recovery and skill center/clubhouse for the Deaf and Hard of Hearing	Assist clients who are deaf and hard of hearing to achieve a more adaptive level of functioning	Adults/Older Adults, Transition Age Youth 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 for deaf and hard-of-hearing Transition Age Youth and Adults/Older Adults who are at risk of or recovering from a mental health issue including those who may have a co-occurring substance use disorder • 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
ALL-OE	Mental Health and Primary Care Services Integration Services	Provide services and treatment to adult patients with behavioral health problems through the Enhanced Screening, Brief Intervention and Referral to Treatment (SBIRT) model	Provide effective, evidence-based treatment for behavioral health interventions in a primary care setting	Adults 18 to 59 years old	• Mental health assessment • Dual diagnosis screening information • Brief mental health services • Linkages to services as needed	Community Clinic Health Network 7535 Metropolitan Dr. San Diego, CA 92108 (619) 542-4300	All
ALL-OE	Psychiatric and Addiction Consultation and Family Support Services	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	For children, adolescents, Transition Age Youth, Adults/Older Adults	• Psychiatric and addiction consultation • Client education, referral, and linkage to services	Vista Hill Foundation 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5100	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
ALL-SD	Psychiatric Emergency Response Team	Connect law enforcement officers with psychiatric emergency clinicians to serve children and adults 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	Services to all ages, with a focus on veterans, homeless and the Native American community	• Case coordination • Linkage and limited crisis intervention services • Training for law enforcement personnel	PERT, Inc. 1094 Cudahy Pl. Suite 314 San Diego, CA 92110 (619) 276-8112	All
ALL-OE	Survivors of Torture International	Outpatient mental health services to adult and older adult 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	Transition Age Youth, Adults/Older Adults with serious mental illness 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 Confidential location for office (619) 278-2400	All
CY-FSP	ALLY National City & South Bay	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 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 (SED) criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Prime Healthcare Paradise Valley 502 Euclid Ave. Suite 103 National City, CA 91950 (619) 472-4714	1
CY-FSP	Child/Youth Case Management	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 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 (SED) 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

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-FSP	Community Circle	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 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 (SED) criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach & engagement	Family Health Centers - Logan Heights 2204 National Ave. San Diego, CA 92113 (619) 515-2355 Family Health Centers - Spring Valley 3845 Spring Dr. Spring Valley, CA 91977 (619) 515-2318	1, 2, 4
CY-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 offer 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 (SED) criteria.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Union of Pan Asian Communities Children's Mental Health 1031 25th St. Suite C San Diego, CA 92102 (619) 232-6454	1, 4 ,5
CY-FSP	Counseling Cove	Locate and engage homeless and runaway youth for the purpose of increasing access to mental health services	Provide a full range of 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 (SED) criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	San Diego Youth Services Counseling Cove 3427 4th Age, 2nd floor San Diego, CA 92104 (619) 525-9903	1, 4
CY-FSP	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 (SED) criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Community Research Foundation Crossroads Family Center 1679 E. Main St. Suite 102 El Cajon, CA 92021 (619) 441-1907	2

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-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 offer case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of family focused, culturally and linguistically competent, stretched 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 (FFA) homes, who meet medical necessity and serious emotional disturbance (SED) criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services	San Diego Center for Children FFAST 8825 Aero Dr. Suite 110 San Diego, CA 92123 (858) 633-4102	All
CY-FSP	Learning Assistance Center	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 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 (SED) criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach & 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	3, 5
CY-FSP	Merit Academy	Day School Services providing Individual, group and family services 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 family focused, culturally and linguistically competent, stretched 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 (SED) criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach & engagement	Vista Hill 1600 N. Cuyamaca St. El Cajon, CA 92020 (619) 994-7860	2
CY-FSP	Mobile Adolescent Services Team (MAST)	Mental Health assessment and treatment services for students and their families at the Momentum Learning School sites, home, 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 attending a Momentum Learning School who meet medical necessity and serious emotional disturbance (SED) criteria and who may be involved with the juvenile justice system	• 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

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-FSP	North County Lifeline	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 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 (SED) criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach & engagement	North County Lifeline Oceanside 707 Oceanside Blvd. Oceanside, CA 92054 (760) 757-0118 North County Lifeline Vista 200 Michigan Ave. Vista, CA 92084 (760) 726-4900	5
CY-FSP	Nueva Vista Family 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 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 (SED) 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
CY-FSP	Palomar Family Counseling 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 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 (SED) criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach & engagement	Palomar Family Counseling Escondido 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660 Fallbrook 120 West Hawthorne St. Fallbrook, CA 92028 (760) 731-3235	3, 5
CY-FSP	Para Las Familias	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 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 6 who meet medical necessity and serious emotional disturbance (SED) criteria.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Outreach & engagement	Episcopal Community Services Para Las Familias 1424 30th St. Ste. A San Diego, CA 92154 (619) 565-2650	1
CY-FSP	Pathways Cornerstone	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 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 (SED) 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

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-FSP	Rady OutPatient Psychiatry N.Inland	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 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 (SED) criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach & engagement	Rady Children's Hospital North Inland 625 W. Citracado Pkwy. Suite 102 Escondido, CA 92025 (760) 294-9270	3
CY-FSP	San Diego Center for Children - East Region Outpatient	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 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 (SED) criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach & engagement	San Diego Center for Children East Region Outpatient 7339 El Cajon Blvd. Suite K La Mesa, CA 91942 (619) 668-6200	2
CY-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 offer 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 (SED) criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach & engagement	Rady Children's Hospital Central-East-South 3665 Kearny Villa Rd. Suite 101 San Diego, CA 92123 (858) 966-8471	1, 2 ,4
CY-FSP	School-Based Outpatient Behavioral Health 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 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 (SED) criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Social Advocates for Youth 4275 El Cajon Blvd. Suite 101 San Diego, CA 92105 (619) 283-9624	4
CY-FSP	South Bay Community 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 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 (SED) criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach & engagement	South Bay Community Services 430 F St. Chula Vista, CA 91910 (619) 420-3620	1

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-FSP	Therapeutic Behavioral Services	Intensive, individualized, one-to-one behavioral coaching program available to children/youth up to 21 years old 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 21 years old who are Medi-Cal eligible and who are receiving specialty mental health reimbursable services	• One on one behavioral coaching	New Alternatives - TBS 2535 Kettner Blvd. Suite 1A4 San Diego, CA 92125 (619) 615-0701	All
CY-FSP	Wraparound	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	Fred Finch Wraparound 3434 Grove St. Lemon Grove, CA 91945 (619) 281-3706	All
CY-FSP	WrapWorks	Wraparound offers team based intensive and individualized case mangement 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 Wrapworks 3002 Armstrong St. San Diego, CA 92111 (858) 633-4100 North County 235 W. 5th Ave. Suite 130 Escondido, CA 92025 (760) 466-3984	All
CY-FSP	Youth Enhancement 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 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 (SED) criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach & engagement	San Ysidro Health Center Youth Enhancement Services 3025 Beyer Blvd. Suite E-101 San Diego, CA 92154 (619) 428-5533	1
CY-FSP /CY-OE	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 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 (SED) 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

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-FSP CY-OE	Rady OutPatient Psychiatry N.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 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 (SED) criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach & engagement	Rady Children's Hospital North Coastal 3142 Vista Way Suite 205 Oceanside, CA 92056 (760) 758-1480	3, 5
CY-SD	Behavioral Crisis Center and Mobile Assessment Team Services	Provide mobile crisis mental health services in conjunction with walk-in assessment clinics for the North County region	Reduce the use of emergency and inpatient services, prevent escalation, and promote the management of mental illness	Children and youth who are experiencing a mental health crisis or urgent need for mental health services	• Crisis response • Assessment • Information • Referral • Medication management • Linkage to hospital when required • Follow-up visits	New Alternatives, Inc. North County Crisis Intervention and Response Team 225 West Valley Pkwy. Suite 100 Escondido, CA 92025 (760) 233-0133 1020 S. Santa Fe Ave. Suite B-1 Vista, CA 92084	5
CY-SD	Breaking Cycles	Groups, case management and referrals for youth detained in 2 of the Department of Probations juvenile detention facilities who are at risk for or are victims of commercial sexual exploitation	Screening, identification, groups and referrals for services upon release of youth who are victims of or at risk for commercial sexual exploitation. Services are in collaboration with juvenile probation, child welfare services, and multi-disciplinary teams	Children and youth up to age 21 who are at risk for or are victims of commercial sexual exploitation	• Screening/identification • Group Treatment • Care Coordination • Case Management • Consultation • Community stabilization	San Diego Youth Services Breaking Cycles 2901 Meadow Lark Drive San Diego, CA 92123 (858) 492-2324	All
CY-SD	CASS	Provide mental health services to children and youth who are placed through Child Welfare Services in various foster home placements. Services available by referral from Child Welfare Services	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 meet medical necessity and serious emotional disturbance (SED) criteria who are at risk of changing placement to a higher level of care	• 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 Ste. 599 San Diego, CA 92108 (858) 357-6239	All
CY-SD	Crisis Action & 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 21 years old who meet medical necessity and meet set criteria	• Intensive case management and treatment to stabilize high risk youth • Crisis intervention • Medication services	New Alternatives Inc. Crisis Action & Connection 730 Medical Center Crt. Chula Vista, CA 91911 (619) 591-5740	1

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-SD	Emergency Screening Unit (ESU)	Provide 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 up to 18 years old who are experiencing a psychiatric emergency.	• Multidisciplinary team provides crisis stabilization and emergency medication management. • Linkages to on-going outpatient services and management of children and youth who are not connected to services following stabilization.	New Alternatives Inc. Emergency Screening Unit 730 Medical Center Crt. Chula Vista, CA 91911 (619) 397- 6972	All
CY-SD	Family Youth Liaison (FYL)	The Family Youth Liaison collaborates with Children, Youth and Families (CYF) administrative staff to ensure family and youth voice and values are incorporated into services development and implementation plans and service delivery	To 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 • Serves as the MHSA Issue Resolution point of contact for children and youth up to age 21 served by CYF providers and their families	NAMI San Diego 5095 Murphy Canyon Road, Suite 320 San Diego, CA 92123 858-634-6580	All
CY-SD	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 1 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) criteria. 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) 521-2250 x 3816	All
CY-SD	Incredible Families	Outpatient mental health treatment and support services for children and families involved in Child Welfare Services	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	Vista Hill Foundation East/South Incredible Families Program 4990 Williams Ave. La Mesa, CA 91942 (619) 668-4263 Central/North Central Incredible Families Central 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5160	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-SD	Juvenile Court Clinic	Provides short term (no more than 3 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 (SED) criteria and who are in the juvenile justice or childe 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
CY-SD	Juvenile Forensics Services Stablization Treatment and Transition	Individual/group/family treamtment for youth in the Department of Probations 4 juvenile dentention facilities and transitional mental heath and case management serivces for those youth who meet criteria upon release	Ensuring that 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 the age of 21currently in detention or in the community who require mental health services to enhance functioning and reduce symptomology	• Individual/group/family treatment • Crisis intervention • Care Coordniation • Case Management • Medication management • Community based mental heath services	County of San Diego Juvenile Forensic Services 2901 Meadowlark Dr. San Diego, CA 92123 (858) 694-4680	All
CY-SD	Multi-Systemic Therapy (MST) / Assertive Community Treatment (ACT)	Offers Multi-Systemic Therapy and Assertive Community Treatment services to children who are at risk of entering the juvenile justice system and are referred by the Department of Probation	Reduce recidivism, prevent youth from entering into the juvenile justice system, and maximize their success in the community	Children and youth up to the age of 21 referred by the department of probation who meet medical necessity and serious emotional disturbance (SED) criteria	• Individual/family treatment • Care coordination • Case management • Rehabilitative services • Medication services	San Diego Unified School District Multi-Systemic Therapy (MST) / Assertive Community Treatment (ACT) 4166 Euclid Avenue San Diego, CA 92105 (619) 344-5636	4
CY-SD	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 (SED) 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 • GED preparation • Support groups • Youth Partners • Mentors	San Diego Youth Services Our Safe Place 3427 4th Avenue San Diego, CA 92103 (619) 525-9903	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-SD	Phoenix House	Certified mental health program providing co-occurring mental health and substance abuse treatment for youth that reside at Phoenix House Academy, Lake View Terrace Residential facility	Integrated treatment of co-occurring mental health and substance use disorder issues for youth residing in the residential program in order to return to a lower level of care or return to home environment	Youth placed in contracted residential substance use disorder program by County of San Diego Probation or Child Welfare Services with co-occurring mental health concerns	• Assessment • Medication management services • Case management • Group therapy / individual therapy and family therapy	Phoenix House of San Diego Inc. 11600 Eldridge Ave. Lake View Terrace, CA 91342 (818) 686-3272	All
CY-SD	Polinsky	Provide mental health assessment and treatment services to children and youth for a short term assessment period while at Polinsky Children's Center. Collaboration with Child Welfare Services for transition plan to enhance permanency and stability	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 (SED) 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) 357-6879	All
CY-SD	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 (ILS) services to Child Welfare Services youth in placement. These services result in integrated treatment services for youth with co-occurring mental health substance abuse 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 (SED) criteria	• Individual/group/family treatment • Care Coordination • Case Management • Rehabilitative Services • Medication services • Independent Living Skills (ILS)	San Diego Center for Children 3003 Armstrong St. San Diego, CA 92111 (858) 277-9550	All
CY-SD	San Pasqual Academy Children's Mental Health Services	Individual/group/family services to children and youth in an academy setting to support self-sufficiency. Provides peer mentorship services to Child Welfare Services youth in placement to foster adolescent growth towards independence and self sufficiency	Supports adolescent growth towards independence and self sufficiency for youth preparing to exit the foster care system	Children and youth at San Pasqual Academy ages 12-21 years old who meet medical neessity and serious emotional disturbance (SED) criteria	• Individual/group/family treatment • Care Coordination • Case Management • Rehabilitative Services • Medication services • Independent Living Skills (ILS)	New Alternatives Inc. San Pasqual Academy 17701 San Pasqual Valley Rd. Escondido, CA 92025 (760) 233-6005	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-OE	Family and Youth Partnership	Outreach and Engagement mental health services to Latino, Asian, and African American children, youth and their families	Outreach and Engagement services for children, youth, up to age 21, and families	Latino, Asian and African American children and youth up to age 21	• Outreach & engagement • Family Support Partners • Case Management • Focus Groups • Support and Education Groups • Community Presentations	Harmonium Inc. 5275 Market St. Suite E San Diego, CA 92114 (619) 857-6799	4
CY-OE	Homeless Outreach	Homeless Outreach workers have been imbedded in each of the 6 regional Women's Perinatal Outpatient Substance Use Disorder Treatment Services for women who may have a serious mental illness and co-occurring disorder	Collaborate with providers of services to the homeless to engage homeless or near homeless individuals with substance use disorders	Pregnant, parenting and perinatal women with mental health and substance use disorders and have dependent children up to 17 years	• Screening, referral, and linkage to services • Case management	TBD	All
CY-OE	Incredible Years	Provide services to children 0 to 5 years old and their families at designated preschool sites in San Diego Unified School District	Increase pro-social behaviors in children through working with the child, parents, and teachers through parenting groups, children's treatment groups, and individual and family services as needed	Children and youth ages 0 to 5 diagnosed with serious emotional disturbance and their families	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Incredible Years Emerson Elementary 3510 Newton Ave. Bungalow 103 San Diego, CA 92113 (619) 238-0471	1, 4
CY-OE	Mental Health Systems Inc.	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	IProvide 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 (SED) 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	4
CY-OE	TIDES	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 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 21 years old 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

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Distr icts
TAOA-FSP	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	• Medication management and monitoring • Individual therapy • Outpatient substance use disorder treatment • Case management • Employment support • Peer counseling and support • Housing services	ACTION Central 6244 El Cajon Blvd. Suites 15-18 San Diego, CA 92115 (858) 380-4676	1
TAOA-FSP	ACTION East	Services for homeless persons with serious mental illness or substance use disorder	The planned hybrid model will integrate Assertive Community Treatment intensive case management services with substance use disorder treatment and recovery services	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	ACTION East 10201 Mission Gorge Rd. Suite O Santee, CA 92071 (619) 383-6868	2
TAOA-FSP	Assisted Outpatient Treatment (AOT)	Intensive community-based services for persons who establish an AOT court settlement agreement, persons who are court-ordered to receive AOT, and for persons who otherwise meet the AOT eligibility criteria and voluntarily accept AOT-alternative services prior to an AOT 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 AOT candidates by the County-identified entity which serves potential AOT candidates (IHOT), have agreed to an AOT court settlement, or have AOT status resulting from a contested court hearing	Only individuals 18 years and older meeting 9 criteria as established under Laura's Law	• ACT services with a rehabilitation and recovery focus to Adults/Older Adults with a serious mental illness or co-accruing substance use disorder	Telecare Corporation 1660 Hotel Circle N. Suite 101 San Diego, CA 92108 (619) 481-3840	All
TAOA-FSP	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	• Full Service Partnership program offering medication support • Case management/brokerage • Crisis intervention • Rehabilitation and other rehabilitative and recovery interventions in a transitional residential setting	Casa Pacifica 321 Cassidy St. Oceanside, CA 92054 (760) 721-2171	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-FSP	Catalyst	Transition Age Youth Assertive Community Treatment Full Service Partnership	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. 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 10-12:1	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 services for transition age youth	Pathways Community Services 7986 Dagget St. San Diego, CA 92111 (858) 300-0460	All
TAOA-FSP	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. 4283 El Cajon Blvd. Suite 115 San Diego, CA 92105 (619) 521-1743	All
TAOA-FSP	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	Adults 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
TAOA-FSP	Collaborative Behavioral Health Court	Use 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 offenders 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

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-FSP	Downtown IMPACT	Fully integrated 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 at-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 years and older who have a serious mental illness and have been homeless, who may be high users of acute inpatient care and medical services and who have resided in the Urban Downtown area of the City of San Diego	• Linkage to food, housing and/or physical health services • Medication management • Vocational services • Substance use disorder services	Community Research Foundation IMPACT 1260 Morena Blvd. Suite 100 San Diego, CA 92110 (619) 398-0355 Downtown IMPACT 995 Gateway Center Way Suite 300 San Diego, CA 92102 (619) 398-2156	1, 4
TAOA-FSP	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, and are residents of San Diego County	Provides 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 and are residents of San Diego County	• Crisis residential services as an alternative to hospitalization or step down from acute in-patient care within a hospital for adults with acute and serious mental illness, including those who may have a co-occurring substance use disorder	Community Research Foundation 490 N. Grape St. Escondido, CA 92025 (760) 975-9939	All
TAOA-FSP	Gateway to Recovery	Provide 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	Provides Assertive Community Treatment Services to persons with very 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	• 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 • Probation-funded Assertive Community Treatment component	Telecare Corporation 3132 Jefferson St. San Diego, CA 92110 (619) 683-3100	All
TAOA-FSP	North Star ACT SBCM	Full Service Partnership / Assertive Community Treatment with supportive housing and Strengths-Based Case Management	Reduce homelessness and provides comprehensive ACT 'wraparound' mental health services for those adults with most severe illness, most in need due to severe functional impairments, and who have not been able to be 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 • Full Service Partnership - Assertive Community Treatment Team services in the North County	MHS, Inc. Escondido 474 W. Vermont Ave. Suite 104 Escondido, CA 92025 (760) 294-1281	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-FSP	Pathways to Recovery	Assertive Community Treatment and In-Reach for adults in and discharged from long-term care	Services are designed using the Assertive Community Treatment model and provided by a trans-disciplinary team of professional and paraprofessional staff such as: counselors, social workers, peer specialists, vocational specialists, housing specialists, nurses, nurse practitioners, physician's assistants, medical doctors, and substance use disorder specialists	Adults 18 to 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 very 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	Telecare Corporation 3132 Jefferson St. San Diego, CA 92110 (619) 683-3100	All
TAOA-FSP	Probation-FSP-ACT Team	The Probation Department provides a wide array of services to the San Diego community, including 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. Probation staff work in the community to help prevent criminal activity, and operate detention facilities for both adults and juveniles	Reduce incarceration and institutionalization, provide timely access to services, and reduce homelessness	Young adults and adults who have a serious mental illness	• Mental health assessments • Interventions • Case management • Outreach and engagement	Probation Administration 9444 Balboa Avenue San Diego, CA 92123 (858) 514-3148	All
TAOA-FSP	Rep Payee	Payee case management services	Key component of the program is increasing clients' money management skills	Adults 18 years and older	• Payee Case Management with a rehabilitation and recovery focus to adults who meet eligibility criteria • Increasing clients' money management skill • Bio-Psycho-Social Rehabilitation (BPSR) principles, shall be evident and operationalized in Contractor's policies, program design and practice	NAMI San Diego Adult Outpatient 5095 Murphy Canyon Rd. San Diego, CA 92123 (858) 634-6590	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-FSP	Senior IMPACT	Offer 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 health issues	• Linkage to food, housing and/or physical health services • Medication management • Vocational services • Substance use disorder services	Senior IMPACT 928 Broadway San Diego, CA 92102 (619) 977-3716	All
TAOA-FSP	Telecare Agewise	Strengths-Based Case Management (SBCM) Full Service Partnership program for Older Adults	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services	Adults/Older Adults who have a serious mental illness	• Care coordination and rehabilitation services for 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 • Services are field based and have a participant-to-staff ratio that is approximately 25:1. The ICM component provides case management for adults 60 years and older who are on Public Conservatorship and reside in a skilled nursing facility or other County-identified long-term care institution	Telecare Corporation Telecare Agewise 6160 Mission Gorge Rd. Suite 108 San Diego, CA 92120 (619) 481-5200	All
TAOA-FSP	Transition Team	Provide Short-term Intensive Transition Team to serve individuals 18 years and older 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 to serve individuals 18 years and older who are or have recently been hospitalized	Telecare Corporation 3132 Jefferson St. San Diego, CA 92110 (619) 683-3100	All
TAOA-FSP	Uptown Safe Haven	Residential transitional housing program that provides supportive services for those who are homeless and have a serious mental illness	Provide residential support, crisis intervention, and transitional housing services	Adults/Older Adults who are homeless with a serious mental illness	• Temporary housing for eligible individuals • Provide food • Linkage to transitional housing • Case management	Uptown Safe Haven Transitional Housing 2822 5th Ave. San Diego, CA 92103 (619) 294-7013	All
TAOA-FSP	Urban Street Angels (Transitional Shelter Beds for Transition Age Youth)	Supplemental housing for Transitional Age Youth in an independent living environment	The provision of housing and support services to homeless mentally ill Transition Age Youth by providing accessible short-term and transitional beds for identified clients	Homeless mentally ill Transition Age Youth	• Emergency shelter and transitional beds for transitional age youth	Urban Street Angels, Inc. 3090 Polk Ave. San Diego, CA 92104 (619) 415-6616 Shelter Sites: 5308 Churchward St. San Diego, CA 92114 (male house) 4634 Bancroft St. San Diego, CA 92116 (female house)	4

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Areta Crowell Clinic	Bio-Psychosocial Rehabilitation (BPSR) 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 who have a serious mental illness	• Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults age 18 years and older who have serious mental illness , including those who may have a co-occurring substance use disorder • Services provided at a Bio-Psychosocial Rehabilitation (BPSR) Wellness Recovery center	Areta Crowell BPSR Program 1963 4th Ave. San Diego, CA 92101 (619) 233-3432 ext. 1308	1, 4
TAOA-SD	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	• Outpatient mental health rehabilitation • Recovery services • Case management • Mobile outreach • Long-term vocational services	UPAC BPSR Mid City 5348 University Ave. Suites 101 &120 San Diego, CA 92105 (619) 229-2999 UPAC BPSR Serra Mesa 8745 Aero Dr. Suite 330 San Diego, CA 92123 (858) 268-4933	1, 4
TAOA-SD	Carroll's Community Care	Augmented Services Program (ASP)	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 licensed 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	Carroll's Community Care 523 Emerald Ave. El Cajon, CA 92020 (619) 442-8893	2
TAOA-SD	Carroll's Residential Care	Augmented Services Program (ASP)	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Elderly who have a serious mental illness and reside in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licensed 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	Carroll's Residential Care 655 S. Mollison St. El Cajon, CA 92020 (619) 444-3181	2
TAOA-SD	Casa Del Sol Clubhouse	South Region (Southern Area) Clubhouse	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	CRF South Bay Casa del Sol Clubhouse 1157 30th St. San Diego, CA 92154 (619) 429-1937	1

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Chipper Chalet Emergency Shelter Beds	Emergency Shelter Services for Adults with serious mental illness	Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Voluntary adults who have a serious mental illness, have no stable income, and are homeless	• Provides shelter and food in a residential setting that has staff available during all operating hours • Provides safe and sanitary quarters on a nightly basis and in a location acceptable to the County, work with, and coordinate services with designated County-contracted Peer Support Services program to promote delivery of peer support services	Chippers Chalet 835 25th St. San Diego, CA 92102 (619) 232-7406	4
TAOA-SD	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 relevant 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	RI International 3565 Del Rey St. Suite 202 San Diego, CA 92109 (858) 274-4650	All
TAOA-SD	Community Wellness Center	Certified Bio-Psychosocial Rehabilitation (BPSR) 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	Adults 18 years and older who have a serious mental illness	• Outpatient mental health clinic providing Medi-Cal certified treatment, rehabilitation, and recovery services to adults 18 years and older, living in San Diego County who have serious mental illness, including those who may have a co-occurring substance use disorder • This clinic offers walk in service during their normal hours of operation	New Leaf Recovery Center 3539 College Ave. San Diego, CA 92115 (619) 818-1013	4
TAOA-SD	Country Club Guest Home	Augmented Services Program (ASP)	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 licensed 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	Country Club Guest Home 25533 Rua Michelle Escondido, CA 92026 (760) 747-0957	3

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Crisis Stabilization Unit	Provide a 24-hour, seven days a week hospital-based Crisis Stabilization Unit in the North Inland Health and Human Services Agency region of North County for adult and older adult Medi-Cal beneficiaries who are residents of San Diego County; who have serious mental illness and 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 serious mental illness	• Provide a twenty-four (24) hour, seven (7) days a week hospital-based Crisis Stabilization Unit (CSU) in the North Coastal Health and Human Services Agency (HHSA) region of North County for adult and older adult Medi-Cal beneficiaries who are residents of San Diego County; who have serious mental illness and who are experiencing a psychiatric emergency, which may also include co-morbid substance use disorder induced problems	Tri-City Medical Center 4002 Vista Way Oceanside, CA 92056 (760) 724-8411	3, 5
TAOA-SD	Crisis Stabilization Unit	Provide a 24-hour, seven days a week hospital-based Crisis Stabilization Unit in the North Inland Health and Human Services Agency region of North County for adult and older adult Medi-Cal beneficiaries who are residents of San Diego County; who have serious mental illness and who are experiencing a psychiatric emergency, which may also include co-morbid substance use disorder problems	Crisis Stabilization	Voluntary and involuntary adults with a serious mental illness	• Provide a twenty-four hour, seven days a week hospital-based Crisis Stabilization Unit (CSU) in the North Coastal Health and Human Services Agency region of North County for adult and older adult Medi-Cal beneficiaries who are residents of San Diego County; who have serious mental illness and who are experiencing a psychiatric emergency, which may also include co-morbid substance use disorder induced problems	Palomar Health 555 E. Valley Pkwy. Escondido, CA 92025 (760) 739-3000	3, 5
TAOA-SD	Discovery Clubhouse	Mental health weekend clubhouse services	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Underserved adults/ older adults 18 years and older with serious mental illness who may have a co-occurring substance use disorder	• Provides a community meeting place and support setting where resources, knowledge, and experience can be offered to the priority population of individuals recovering from serious mental illness • Assist clients with increasing their social and vocational rehabilitation skills; reducing social isolation; and increasing independent functioning and employment	Alvarado Parkway Institute Discovery Clubhouse 5538 University Ave. San Diego, CA 92105 (619) 667-6176	1, 4
TAOA-SD	Douglas Young BPSR Ctr.	North Central 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 for clients 18 years and older with serious mental illness, including those who may have a co-occurring substance use disorder	CRF - Douglas Young 10717 Camino Ruiz Suite 207 San Diego, CA 92126 (858) 695-2211	1, 4

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Downtown Safe Haven	Adult mental health emergency shelter beds	Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Voluntary adults who have serious mental illness, have no stable income and are homeless	• Provides shelter and food in a residential setting that has staff available during all operating hours • Provides safe and sanitary quarters on a nightly basis and in a location acceptable to the County, work with, and coordinate services with designated County-contracted Peer Support Services program to promote delivery of peer support services	Downtown Safe Haven 1425 C St. San Diego, CA 92101 (619) 238-8300	4
TAOA-SD	East Corner Clubhouse	East Region member operated clubhouse	Provides clubhouse services	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	Community Research Foundation East Corner Clubhouse 1060 Estes St. El Cajon, CA 92020 (619) 631-0441	2
TAOA-SD	Episcopal Community Services Friend to Friend (F2F) Clubhouse	Provides a street outreach and site-based program to engage homeless adults with serious mental illness, including Veterans, 18 years and older, 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	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services • Services are in Central Region with an emphasis in downtown San Diego	Episcopal Community Services Friend-to-Friend Program Homeless Services Program 2144 El Cajon Blvd. San Diego, CA 92104 (619) 228-2800	4
TAOA-SD	Escondido Clubhouse	Clubhouse services in the North Inland Region	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Adults/Older Adults	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	North Inland Region Mental Health Systems, Inc. Escondido Clubhouse 474 W. Vermont Ave. Suite 105 Escondido, CA 92025 (760) 737-7125	3
TAOA-SD	Family Mental Health Education & Support	Provide a series of educational classes presented by family members using an established family education curriculum to provide education and support for persons who have relatives (or close friends) with mental illness	Promote integration of family education services. Increase family involvement, coping skills and improving 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 of persons with serious mental illness using an established family education curriculum to provide education and support for persons who have relatives or close family friends with mental illness • Increase family member's coping skills and support increased involvement and partnership with the mental health system	NAMI San Diego Family Education Services 5095 Murphy Canyon Rd. Suite 125 San Diego, CA 92123 (619) 398-9851	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Fancor Guest Home	Augmented Services Program (ASP)	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 licensed 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	Fancor Guest Home 631 651 Taft Ave. El Cajon, CA 92020 (619) 588-1761	2
TAOA-SD	Friendly Home II	Augmented Services Program (ASP)	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 licensed 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	Liliosa D. Vibal Friendly Home II 504 Ritchey St. San Diego, CA 92114 (619) 263-2127	1, 4
TAOA-SD	Friendly Home of Mission Hills	Augmented Services Program (ASP)	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 licensed 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	Liliosa D. Vibal Friendly Home of Mission Hills 3025 Reynard Way San Diego, CA 92103 (619) 297-1841	4
TAOA-SD	Heartland Center	Provides Adults/Older Adults Bio-Psychosocial Rehabilitation (BPSR) clinical outpatient services that integrate mental health services and rehabilitation treatment and recovery services	Provides 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 disorder, 18 years and older including those who may have a co-occurring substance use disorder	• 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. Includes Probation-funded AB 109 component	East Region CRF Heartland Center 1060 Estes St. El Cajon, CA 92020 (619) 440-5133	2

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Homefinder	Housing support for BHS adult clinics	Identify and secure safe and affordable housing	Adults who are enrolled in COR designated BHS programs with serious mental illness who are homeless or at risk	• The Home Finder program serves clients, who are 18 years and older, in identifying and securing safe and affordable housing. Clients must be enrolled in designated Behavioral Health Services (BHS) contracted or county outpatient mental health clinic, have housing instability due to being homeless or at-risk of homelessness • Housing options may include both single and shared occupancy. The Home Finder program will create, update and provide BHS designated program access to a centralized hub for housing resources and roommate matching services • The program provides flex funds to support resident retention. The program also provides housing resources and education to clients, staff, and landlords regarding affordable housing for people with serious mental illness	Alpha Project for the Homeless 3860 Calle Fortunada San Diego, CA 92113 (619) 542-1877	4
TAOA-SD	In Home Outreach Team IHOT Central/East/ South	Mobile In Home Outreach Teams (IHOT) in the South Regions	The goal of this program is to 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 who are reluctant to seek treatment	• In Home Mobile Outreach for Adults/Older Adults with a serious mental illness	Telecare Corporpation - IHOT 1080 Marina Village Pkwy. Suite 100 Alameda, CA 94501 (619) 961-2120	1, 2, 4
TAOA-SD	In Home Outreach Team IHOT - North Inland, North Central	In-home Outreach Team - Mobile Outreach and Linkage North Coastal, North Inland, North Central	The goal of this program is to 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 for Adults/Older Adults with a serious mental illness	Mental Health Systems - IHOT North Coastal, North Inland, North Central 365 Rancho Santa Fe Rd. Suite 100 San Marcos, CA 92078 (760) 591-0100	5
TAOA-SD	Interfaith Community Services Emergency Shelter Beds	Emergency Shelter Services for Adults with serious mental illness	Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Voluntary adults who have a serious mental illness, have no stable income, and are homeless	• Provides shelter and food in a residential setting that has staff available during all operating hours • Provides safe and sanitary quarters on a nightly basis and in a location acceptable to the County, work with, and coordinate services with designated County-contracted Peer Support Services program to promote delivery of peer support services	Interfaith Community Services Administration 550 W. Washington St. Suite B Escondido, CA 92025 (760) 489-6380	4

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Jane Westin Wellness & Recovery Center	Walk-in Services - Assessment Center	Provide one time, short-term 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 a serious mental illness	• Walk-In center 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	Jane Westin Wellness & Recovery Center 1568 6th Ave. San Diego, CA 92101 (619) 235-2600 ext. 201	1, 4
TAOA-SD	Liaison Services	Client liaison services aims to increase client participation and involvement in the Behavioral Health Services (BHS) Adult and Older Adult System of Care (AOASOC) through the implementation of the client liaison function, providing peer advocacy throughout the AOASOC	Develop and coordinate continuous efforts toward increasing client involvement, participation and partnership in the development and implementation of existing and evolving BHS AOASOC policies, practices and programs in order to ensure client needs are accommodated	Adults 18 years and older who have a serious mental illness living in San Diego county	• Increase client participation and involvement in the County Behavioral Health Services (BHS) Adult and Older Adult System of Care (AOASOC) through the implementation of the Client Liaison function, providing peer advocacy throughout the AOASOC. ("Client" is defined as someone who has been diagnosed with a serious mental illness and receives services from the AOASOC)	RI International 3565 Del Rey St. Suite 202 San Diego, CA 92109 (858) 274-4650	All
TAOA-SD	Logan Heights Family Counseling	Provides outpatient, case management/ brokerage and vocational support services for indigent clients with serious mental illness 18 years and older including those who may have a co-occurring substance use disorder	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services	Adults/Older Adults individuals who have serious mental illness/co-occurring disorder and are eligible for Medi-Cal or are indigent	• Bio-psychosocial rehabilitation (BPSR) wellness recovery center in the Central Region that provides outpatient mental health, case management/brokerage, and peer support for indigent adults with serious mental illness, including those who may have a co-occurring substance use disorder • Provide rehabilitative, recovery and vocational services and supports to the target population	Family Health Centers Logan Heights 2204 National Ave. San Diego, CA 92113 (619) 515-2355	1, 4
TAOA-SD	Luhman Center for Supportive Living	Augmented Services Program (ASP)	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 licensed 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	Volunteers of America 3530 Camino Del Rio N. Suite 300 San Diego. CA 92108 (619) 282-8211	All
TAOA-SD	Maria Sardiñas Center	South Region (Southern Area) Strengths-Based Case Management	Provides strengths-based case management services	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 AB109 component	• Outpatient mental health clinic providing strengths-based case management services to adults 18 years and older, Transition Age Youth & AB109 who have serious mental illness including those who may have a co-occurring substance use disorder	Maria Sardiñas Wellness & Recovery Center 1465 30th St. Suite K San Diego, CA 92154 (619) 428-1000	1

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Mariposa Clubhouse	Clubhouse services in the North Coastal Region	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Adults/Older Adults	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	North Coastal Region Mental Health Systems, Inc. Mariposa Clubhouse 560 Greenbrier Dr. Suite C-E Oceanside, CA 92054 (760) 439-2785	5
TAOA-SD	Mark Alane Inc. Chipper's Chalet	Augmented Services Program (ASP)	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 licensed 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	Chipper's Chalet Augmented Services Program 835 25th St. San Diego, CA 92102 (619) 234-5465	4
TAOA-SD	Mark Alane, Inc. The Broadway Home	Augmented Services Program (ASP)	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 licensed 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	The Broadway Home 2445 Broadway San Diego, CA 92102 (619) 232-7406	1, 4
TAOA-SD	Mental Health Systems, Inc. Serial Inebriate Program	Serial Inebriate Program (SIP) Non-residential substance use disorder treatment and recovery services	Support integrated treatment of chronic serial inebriants. Stabilization, recovery and reducing stigma associated with mental health concerns and provides additional support or referrals	Adults/Older Adults SIP clients referred by SDPD SIP Liaison Officer	• Non-residential substance use disorder treatment and recovery service center focus of court sentenced chronic public inebriates as an alternative to custody. Serves those who may have a co-occurring mental health disorder and chronic inebriants working in conjunction with the SDPD Homeless Outreach Team (HOT) • Services include individual and group counseling, case management, housing and linkages to other relevant services	MHS SIP Program 3340 Kemper St. San Diego, CA 92118 (619) 523-8121	4
TAOA-SD	Neighborhood House Association Friendship Clubhouse	Member-operated clubhouse program in the central region	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of 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	• Provides rehabilitation services to adults/older adults who are low income or Medi-Cal eligible and are diagnosed with a serious mental illness and/or may have a co-occurring substance use disorder • 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 Friendship Clubhouse 286 Euclid Ave. San Diego, CA 92114 (619) 266-9400	1, 4

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Nelson-Haven	Augmented Services Program (ASP)	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 licensed 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	Nelson-Haven Board and Care 1268 22nd St. San Diego, CA 92102 (619) 233-0525	1, 4
TAOA-SD	North Coastal Mental Health Clinic and Vista BPSR Clinic	Outpatient mental health and rehabilitation and recovery, crisis walk in, peer support, homeless outreach, case management and long term vocational support	Increase mental health services for transition age youth (Transition Age Youth). Decrease incidence of homelessness. Increase client's self-sufficiency through development of life skills	Transition Age Youth, Adult & Older Adult	• Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults age 18 years and older who have serious mental illness, including those who may have a co-occurring substance use disorder	MHS North Coastal Mental Health Center 1701 Mission Ave. Oceanside, CA 92058 (760) 967-4483 MHS BPSR Vista 550 West Vista Way Suite 407 Vista, CA 92083 (760) 758-1092	5
TAOA-SD	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	• 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	MHS North Inland Mental Health Center 125 W. Mission Ave. Escondido, CA 92025 (760) 747-3424 MHS Kinesis North WRC 474 W. Vermont Ave. 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 Ave. Suite 101 Escondido, CA 92025 (760) 480-2255	3

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	North Inland RRC	Regional Recovery Center - Non-residential substance use disorder treatment and recovery services	To assist individuals in becoming and remaining free of substance use disorder problems. For co-occurring clients, the goal is to 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 free life style	Adults with substance use disorder problems, including co-occurring disorders	• Screening for mental health issues • Linkage to mental health services	North Inland RRC 200 E. Washington Ave. Suite 100 Escondido, CA 92025 (760) 741-7708	5
TAOA-SD	Oasis Clubhouse	Transition Age Youth Member Operated Clubhouse	Member-driven center that assists transitional-age youth 16 to 25 years old diagnosed with a serious mental illness (who may have a co-occurring substance use disorder) 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 with serious mental illness who reside in San Diego County	• Provides clubhouse services to transitional-age youth 16 to 25 years old diagnosed with a serious mental illness and/or have a co-occurring substance use disorder	Pathways Community Services 3330 Market St. Suite C San Diego, CA 92102. (858) 300-0460	All
TAOA-SD	Orlando Residential Care	Augmented Services Program (ASP)	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 licensed 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	Orlando Guest Home LLC 297-299 Orlando St. El Cajon, CA 92021 (619) 444-9411	2
TAOA-SD	Patient Advocacy Services	Patient Advocacy Services for mental health clients will be expanded to County-Identified Skilled Nursing Facilities with Augmented Services Programs	Provides on-going support/advocacy services and training to staff and residents at County-identified Board and Care facilities with ASPs. Expands services for County-Appointed Patient Advocate	Adults and children	• 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

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Positive Solutions	Assessments and brief intervention for home bound seniors	Increase the number of Older Adults with a serious mental illness and Transition Age Youth receiving integrated, culturally specific mental health services countywide	Underserved culturally/ethnically diverse or isolated seniors at risk for depression, suicide and substance use disorder	• Mobile outreach and engagement • Mental health assessment & treatment • Rehabilitation and recovery services • Linkage to community services and care coordination • Employment and education support	UPAC Midtown Center 5348 University Ave. Suites 101 & 120 San Diego, CA 92105 (619) 229-2999	3, 4, 5
TAOA-SD	Project Enable Outpatient Program	Provides a Short-Doyle Medi-Cal (SD/MC) certified Bio-Psychosocial Rehabilitation (BPSR) 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. Transitions Transition Age Youth and coordinates transitional services between its outpatient program and HHSA Children, Youth and Family Mental Health Services and other Transition Age Youth providers	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 • Transitions Transition Age Youth and coordinates transitional services between its outpatient program and HHSA Children, Youth and Family Mental Health Services and other providers	NHA Project Enable 286 Euclid Ave. San Diego, CA 92114 (619) 266-9400	1, 4
TAOA-SD	Project In-Reach	Provide 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 community aftercare	The program is focused on serving 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	NHA Project In-Reach 286 Euclid Ave. Suite 102 San Diego, CA 92114 (619) 266-9400	All
TAOA-SD	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 (DTU) will reduce untreated mental illness by ensuring persons are connected to system of care	Clients with a serious mental illness who are incarcerated adults or Transition Age Youth at designated detention facilities and will be released in San Diego County	• Discharge planning • Care coordination • Referral and linkage • Short term case management	Public Defender 450 B Street Ste 1100 San Diego, CA 92101	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Ruby's House Independent Living	Emergency shelter services for mentally ill adults	Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Voluntary adults who have a serious mental illness, have no stable income and are homeless	• Provide shelter and food in a residential setting that has staff available during all operating hours • Provide safe and sanitary quarters on a nightly basis and in a location acceptable to the County • Coordinate services with designated County-contracted Peer Support Services program to promote delivery of peer support services	Ruby's House Independent Living Facility 1702 Republic St. San Diego, CA 92114 (619) 756-7211	2
TAOA-SD	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 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. Employment Solutions 10981 San Diego Mission Rd. Suite 100 San Diego, CA 92108 (619) 521-9569	4
TAOA-SD	South Bay Guidance Wellness and Recovery Center	South Region (Northern Area) strengths-based case management	Provides 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 health clinic providing treatment, rehabilitation, recovery, and SBCM to adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder	South Bay Guidance Wellness and Recovery Center 835 3rd Ave. Suite C Chula Vista, CA 91911 (619) 429-1937	1
TAOA-SD/CY-SD	SSI Advocacy Services	Supplemental Security Income (SSI) Advocacy services. Responsible for the submission of SSI applications to the Social Security Administration (SSA) and further follow-up as needed.	To expedite SSI awards, to provide training and consultation to designated Clubhouses SSI advocates, and to 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 San Diego County .	• Provides Supplemental SSI Advocacy Services for consumers of the following programs: General Relief (GR); Cash Assistance Program for Indigents (CAPI), County Medical Services (CMS), and mental health consumers of San Diego County through a collaborative effort with the Contractor and designated SSI Advocates of the San Diego County Behavioral Health Services “Clubhouse” program. • Provides SSI advocacy services (outreach, education, consultations, and SSI applications processing) for children and youth up to age 18 with an emphasis on those eligible for, or served by Behavioral Health Services Children's System of Care who meet SSI eligibility criteria.	Legal Aid 110 South Euclid Ave. San Diego, CA 92114 (877) 734-3258	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	START Vista Balboa, New Vistas, Halcyon, Crisis Center, Turning Point, Jary Barreto, Isis Crisis Center	Mental Health Short Term Acute Residential Treatment (START)	Provides urgent services in North Coastal, Central, East and South Regions of San Diego to meet the community identified needs	Voluntary adults 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	• 24-hour, 7-day a week, 365 day a year crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital for adults with acute and serious mental illness, including those who may have a co-occurring substance use disorders, and are residents of San Diego County	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) 232-7048 CRF Isis Crisis Center 619-575-4687	All
TAOA-SD	Supported Employment Technical Consultant Services	Provides consultant services for increased employment opportunities for adults with serious mental illness	Develop Strategic Employment Plan, and destigmatize mental health in the workplace	Does not serve clients directly	• Technical expertise and consultation on county-wide employment development, partnership, engagement, and funding opportunities for adults with serious mental illness	San Diego Workforce Partnership 3910 University Ave. Suite 400 San Diego, CA 92105 (619) 228-2900	All
TAOA-SD	The Broadway Home Emergency Shelter Beds	Emergency Shelter Services for Adults with serious mental illness	Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Voluntary adults who have a serious mental illness, have no stable income, and are homeless	• Provides shelter and food in a residential setting that has staff available during all operating hours • Provides safe and sanitary quarters on a nightly basis and in a location acceptable to the County, work with, and coordinate services with designated County-contracted Peer Support Services program to promote delivery of peer support services	The Broadway Home 2445 Broadway San Diego, CA 92102 (619) 232-7406	4
TAOA-SD	The Corner Clubhouse	Member-operated clubhouse program in the Central Region	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Adults/Older Adults with a serious mental illness, 18 years and older including those who may have a co-occurring substance use disorder	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	The Corner Clubhouse 2864 University Ave. San Diego, CA 92104 (619) 683-7423	4

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	The Meeting Place	Mental Health Clubhouse/Supplemental Social Security Income Advocate and Peer Support Line. The program 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	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 serious mental illness including those who may have a co-occurring substance use disorder	• Provides rehabilitative, recovery, health and vocational services and supports to the target population	The Meeting Place 2553 & 2555 State St. Suite 101 San Diego, CA 92103 (619) 294-9582	4
TAOA-SD	Troy Center for Supportive Living	Augmented Services Program (ASP)	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 licensed 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	Volunteers of America Troy Center for Supportive Living 8627 Troy St. Spring Valley, CA 91977 (619) 465-8792	2
TAOA- SD	UCSD IHOT and AOT Service Evaluation	Conduct outcome and program evaluation of In-Home Outreach Teams (IHOT) and Assisted Outpatient Treatment (AOT) services by: 1) Conducting client, family and staff focus groups 2) Evaluating program and outcome data 3) Preparing and submitting to County periodic and final reports of findings and recommendations	Provide outcome and program evaluations of In-Home Outreach Teams (IHOT) and Assisted Outpatient Treatment (AOT) services	Support for the two IHOT programs (IHOT North & TC IHOT) and AOT programs	• Data analysis/ evaluation of serviced provided by In-Home Outreach Teams and Assisted Outpatient Treatment	Regents of the University of California 9500 Gilman Dr. La Jolla, CA 92093 (619) 619-471 ext. 9396	All
TAOA-SD	United Homes Emergency Shelter Beds	Emergency Shelter Services for Adults with serious mental illness	Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Voluntary adults who have a serious mental illness, have no stable income, and are homeless	• Provides additional services to people with serious and prolonged mental illness in licensed 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	United Homes-Emergency Shelter Beds 336 South Horne St. Oceanside, CA 92054 (760) 612-5980	5

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Visions Clubhouse	South Region (Northern Area) Clubhouse	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
TAOA-SD	Vista Walk in Assessment Center; North County Walk in Assessment Center - Escondido	Walk-in services assessment center	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services	Transition Age Youth, Adults/Older Adults	• Walk-In center 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	North County Walk In Assessment Center 1520 South Escondido Blvd. Escondido, CA 92025 (760) 796-7760 Vista Walk In Assessment Center 524 & 500 W. Vista Way Vista, CA 92083 (760) 758-1150	3, 5
TAOA-SD	VOA East County Emergency Shelter Beds	Emergency Shelter Services for Adults with serious mental illness	Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Voluntary adults who have serious mental illness, have no stable income, and are homeless	• Provides shelter and food in a residential setting that has staff available during all operating hours • Provides safe and sanitary quarters on a nightly basis and in a location acceptable to the County, work with, and coordinate services with designated County-contracted Peer Support Services program to promote delivery of peer support services	Volunteers of America 290 S. Magnolia St. El Cajon, CA 92020 (619) 447-2428	2
TAOA-OE	Substance Use Disorder Recovery Center	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	UPAC 3288 El Cajon Blvd. Suites 3,6,10,11,12 & 13 San Diego, CA 92104 (619) 521-5720	4
TAOA-OE	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	18 years and older with substance use disorder induced problems, including those who may have co-occurring mental health disorder	• Non-residential substance use disorder rehabilitation services • Treatment and recovery service center for substance use disorder clients who may also have co-occurring mental health disorders	MITE East Regional Recovery Center 1365 North Johnson Ave. El Cajon, CA 92020 (619) 440-4801	2

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-OE	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	18 years and older with substance use disorder problems, including those who may have co-occurring mental health disorder	• 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, 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
TAOA-OE	Regional Recovery Center - Central	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	Provide outpatient treatment and recovery services to adults with substance use disorder problems, including co-occurring disorders. Adults receive PC 1000 (Deferred Entry of Judgment) drug diversion services	18 years and older with substance use disorder problems, including those who may have co-occurring mental health disorder	• Substance use disorder treatment and recovery services • Adults receive PC 1000 (Deferred Entry of Judgment) drug diversion services	Episcopal Community Services 401 Mile of Cars Way Suite 350 National City, CA 91950 (619) 228-2800 Program Site: 4660 El Cajon Blvd. Suite 210 San Diego, CA 92115 (619) 597-7335	1, 2, 4
TAOA-OE	Solutions for Recovery	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. For co-occurring clients, the goal is to 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 free life style	18 years and older with substance use disorder, including those who may have co-occurring mental health disorder	• Non-residential substance use disorder treatment and recovery services to Transition Age Youth, adults and older adults with substance use disorder problems, including co-occurring mental health disorders •Non-residential substance use disorder treatment and recovery services to LGBTQ adults (as a priority) with substance use disorder-induced problems, including co-occurring disorders • Target adults who have any mental health disorder of sufficient severity, disability and persistence that it would interfere with the person participating successfully in a traditional substance use disorder treatment and recovery program • 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, Secular Organizations for Sobriety	Solutions for Recovery 3928 Illinois St. San Diego, CA 92104 (619) 515-2588	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-OE	South 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. Incorporating evidence-based treatment and recovery services	To 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 an substance use disorder free lifestyle	18 years and older with substance use disorder, including those who may have co-occurring mental health disorder	• 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 Chula Vista, CA 91911 (619) 691-8164	1

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CO-02	Adolescent Group Homes	Adolescent Residential SUD Treatment	Supports integrated treatment of co-occurring disorder issues for those enrolled in substance use disorder treatment. Reduces stigma associated with mental health concerns and provide additional support or referrals according to need	Adolesents and pregnant or parenting adolescents	• Individual, group, family therapy • Substance use disorder counseling • Rehabilitative services, skill building	McAlister Institute for Treatment and Education 1400 North Johnson Ave. Suite 101 El Cajon, CA 92020 (619) 442-2012	All
CO-02	Bill Dawson Research Recovery Program, Short Term I, Short Term II	Provides residential treatment, recovery and ancillary services that are non-institutional and non-medical within licensed and certified residential programs	Assists adult adults to become and remain free of substance use disorder, screen for mental health concerns, and reduce stigma associated with mental health issues	Adults with substance use disorders	• Residential substance use disorder structured program with treatment and/or recovery services available twenty-four hours per day, seven days a week • Mental health screening	CRASH BDRRP 726 F. St. San Diego, CA 92101 (619) 239-9691 Short Term I 4161 Marlborough Ave. San Diego, CA 92105 (619) 282-7274 Short Term II 1081 Camino Del Rio S. Suite 129 San Diego, CA 92108 (619) 297-5131	All
CO-02	Casa Raphael	Provides residential treatment, recovery and ancillary services that are non-institutional and non-medical within licensed and certified residential programs	Assists males who have a history of substance use disorder to become and remain free from substance use disorder, provide mental health screening and referrals and reduce stigma associated with mental health concerns	Adult/older adults males 18 years and older with substance use disorder	• Substance use disorder services for individuals with substance use disorder, structured program with treatment and/or recovery services available twenty-four hours per day, seven days a week • Mental health screening	Alpha Project 993 Postal Way Vista, CA 92083 (760) 630-9922	All
CO-02	Central Southeastern Teen Recovery Center	Non-residential substance use disorder treatment and recovery services	Supports integrated treatment of co-occurring disorder issues for those enrolled in substance use disorder treatment. Reduces stigma associated with mental health concerns and provide additional support or referrals	Adolescents 12 to 17 years old with substance use disorder and other drug-induced problems	• Non-residential substance use disorder treatment and recovery services for adolescents	Vista Hill Foundation 220 North Euclid Ave. Suite 40 San Diego, CA 92114 (619) 795-7232	1, 4

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CO-02	Community Wellness Center	Certified Bio-Psychosocial Rehabilitation (BPSR) 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	Adults 18 years and older who have a serious mental illness	• Outpatient mental health clinic providing Medi-Cal certified treatment, rehabilitation, and recovery services to adults 18 years and older, living in San Diego County who have serious mental illness, including those who may have a co-occurring substance use disorder • This clinic offers walk in service during their normal hours of operation	UPAC New Leaf Recover Center 3539 College Avenue San Diego, CA 92115 (619) 818-1013	4
CO-02	East Regional Recovery Center	Non-residential substance use disorder treatment and recovery service center	Assists 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	18 years and older with substance use disorder, including those who may have co-occurring mental health disorder	• Non-residential • Treatment and recovery service center for clients with including co-occurring mental health disorders • Mental health screening	McAlister Institute for Treatment and Education East Regional Recovery Center 1365 North Johnson Ave. El Cajon, CA 92020 (619) 440-4801	2
CO-02	Regional Recovery Center - Central	Non-residential substance use disorder treatment and recovery service center for adults	Provides outpatient treatment and recovery services to adults with substance use disorder, including co-occurring disorders. Adults receive PC 1000 (Deferred Entry of Judgment) drug diversion services, screen for mental health concerns, and reduce stigma associated with mental health issues	18 years and older with substance use disorder, including those who may have co-occurring mental health disorder	• Treatment and recovery services. Adults receive PC 1000 (Deferred Entry of Judgment) drug diversion services • Mental health screening	Episcopal Community Services 401 Mile of Cars Way Suite 350 National City, CA, 91950 (619) 228-2800 4660 El Cajon Blvd. Suite 210 San Diego, CA 92115 (619) 597-7335	1, 2, 4
CO-02	Family Recovery Center Residential	Women and Perinatal Residential SUD Treatment	Supports integrated treatment of co-occurring disorder issues for those enrolled in substance use disorder treatment. Reduces stigma associated with mental health concerns and provide additional support or referrals	Pregnant or parenting females	• Individual, group, family, child therapy • Substance use disorder counseling • Rehabilitative services, skill building • Childcare • Case management	Mental Health Systems Inc. Family Recovery Center-Residential 1100 Sportfisher Dr. Oceanside, CA 92054 (760) 439-6702	All
CO-02	House of Metamorphosis Inc.	Residential treatment, recovery and ancillary services that are non-institutional and non-medical within licensed and certified residential programs	Assists adults to become and remain free of substance use disorder, screen for mental health concerns, and reduce stigma associated with mental health issues	Adults with substance use disorders	• Residential substance use disorders structured program with treatment and/or recovery services available twenty-four hours per day, seven days a week • Mental health screening	House of Metamorphosis, Inc. 2970 Market St. San Diego, CA 92102 (619) 236-9492	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CO-02	Kiva	Women and Perinatal Residential SUD Treatment	Supports integrated treatment of co-occurring disorder issues for those enrolled in substance use disorder treatment. Reduces stigma associated with mental health concerns and provide additional support or referrals	Pregnant or parenting females	• Individual, group, family, child therapy • Substance use disorder counseling • Rehabilitative services, skill building • Childcare • Case management	McAlister Institute for Treatment and Education 1400 North Johnson Ave. Suite 101 El Cajon, CA 92020 (619) 442-2012	All
CO-02	Adult Drug Court - East County Center for Change	Provides intensive treatment services to offenders with long histories of drug use and criminal justice contacts, previous treatment failures, and high rates of health and social problems	Supports the target population in their efforts to free of substance use disorder, become and remain free from substance use disorder, provide mental health screening and referrals, reduce stigma associated with mental health concerns, screen for mental health concerns, and reduce stigma associated with mental health issues	Non-violent male and female offenders, with a history of substance use disorder and co-occurring disorders, who have been referred to treatment by the Adult Drug Court team and accepted for intake	• Non-residential treatment, recovery, and ancillary services. • Outpatient Drug-Free (ODF) treatment and intensive Day Care Habilitative (DCH) service in an environment free of substance use disorder • Mental health screening	Mental Health Systems Inc. East County Center For Change 545 N. Magnolia Ave. El Cajon, CA 92020 (619) 579-0947	2
CO-02	Adult Drug Court - North County Center for Change	Provides intensive treatment services to offenders with long histories of drug use and criminal justice contacts, previous treatment failures, and high rates of health and social problems	Supports the target population in their efforts to free of substance use disorder, become and remain free from substance use disorder, provide mental health screening and referrals, reduce stigma associated with mental health concerns, screen for mental health concerns, and reduce stigma associated with mental health issues	Non-violent male and female offenders, with a history of substance use disorder and co-occurring disorders, who have been referred to treatment by the Adult Drug Court team and accepted for intake in an environment free of substance use disorder	• Non-residential treatment, recovery, and ancillary services • Outpatient Drug-Free (ODF) treatment and intensive Day Care Habilitative (DCH) services • Mental health screening	Mental Health Systems Inc. North County Center For Change 504 W. Vista Way Vista CA 92083 (760) 940-1836	2, 3, 5
CO-02	Adult Drug Court - San Diego Center for Change	Provides intensive treatment services to offenders with long histories of drug use and criminal justice contacts, previous treatment failures, and high rates of health and social problems	Supports the target population in their efforts to free of substance use disorder, become and remain free from substance use disorder, provide mental health screening and referrals, reduce stigma associated with mental health concerns, screen for mental health concerns, and reduce stigma associated with mental health issues	Non-violent male and female offenders, with a history of substance use and co-occurring disorders, who have been referred to treatment by the Adult Drug Court team and accepted for intake in an environment free of substance use disorder	• Non-residential treatment, recovery, and ancillary services • Outpatient Drug-Free (ODF) treatment and intensive Day Care Habilitative (DCH) services • Mental health screening	Mental Health Systems Inc. San Diego Center For Change 3340 Kemper St. Suite 103 San Diego, CA 92110 (619) 758-1433	4

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CO-02	Drug Court - South County Center for Change	Intensive treatment services to offenders with long histories of drug use and criminal justice contacts, previous treatment failures, and high rates of health and social problems	Supports the target population in their efforts to free of substance use disorder, become and remain free from substance use disorder, provide mental health screening and referrals, reduce stigma associated with mental health concerns, screen for mental health concerns, and reduce stigma associated with mental health issues	Non-violent male and female offenders, with a history of substance use disorder and co-occurring disorders, who have been referred to treatment by the Adult Drug Court team and accepted for intake in an environment free of substance use disorder	• Non-residential AOD treatment, recovery and ancillary services • Outpatient Drug-Free (ODF) treatment and intensive Day Care Habilitative (DCH) services • Mental health screening	South County Center For Change 1172 3rd Ave. Chula Vista, CA 91911 (619) 691-1662	1, 4
CO-02	New Hope Teen Recovery	Adolescent Perinatal SUD Treatment	Supports integrated treatment of co-occurring disorder issues for those enrolled in substance use disorder treatment. Reduces stigma associated with mental health concerns and provide additional support or referrals	Pregnant or parenting adolescent females	• Individual, group, family, child therapy • Substance use disorder counseling • Rehabilitative services, skill building • Childcare	McAlister Institute for Treatment and Education 1400 North Johnson Ave. Suite 101 El Cajon, CA 92020 (619) 442-2012	1, 2, 4
CO-02	North Central Regional Recovery Center (Mid-Coast)	Provides non-residential substance use disorder treatment and recovery services for adults- regional recovery center in the North Central region service area	Assists individuals to become and remain free of substance use disorder. Adults experiencing co-occurring substance use and mental health problems receive services that comprehensively address both disorders, so the individual may achieve a substance use disorder free lifestlye	Transition Age Youth, adults and older adults with substance use disorder, including those with co-occurring mental health issues	• Core functions of a Regional Recovery Center (RRC) • Treatment and recovery services for adults referred from a variety of sources, which may include HHSA Child Welfare Services, mental health programs, the Superior Court, CalWORKs Welfare-to-Work Employment Case Management and Substance Use Disorder Case Management programs, and the Probation Department, among others • Mental health screening	Mid-Coast RRC 3340 Kemper St. San Diego, CA 92110 (619) 523-8121	3, 4
CO-02	North Central Teen Recovery Center	Non-residential substance use disorder treatment and recovery services	Supports integrated treatment of co-occurring disorder issues for those enrolled in substance use disorder treatment. Reduces stigma associated with mental health concerns and provide additional support or referrals	Adolescents 12 to 17 years old with substance use disorder and other drug-induced problems	• Non-residential substance use disorder treatment and recovery services	McAlister Institute for Treatment and Education North Central 7625B Mesa College Dr. Ste. 115B, San Diego, CA 92111 Office: (858) 277-4633	3, 4

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CO-02	North Coastal Regional Recovery Center	Non-residential substance use disorder treatment and recovery service center for adults	Assists 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	18 years and older with substance use disorder, including those who may have co-occurring mental health disorder	• Evidence-based treatment and recovery service approaches • 12-step models (e.g., AA, NA) • Non-12-step models (e.g., SMART Recovery, Rational Recovery, Secular Organizations for Sobriety. • PC 1000 (Deferred Entry of Judgment) drug diversion services to adults • Mental health screening	McAlister Institute for Treatment and Education 2821 Oceanside Blvd. Oceanside, CA 92054 (760) 721-2781	3, 5
CO-02	North Coastal Teen Recovery Center	Non-residential outpatient substance use disorder treatment and recovery services	Supports integrated treatment of co-occurring disorder issues for those enrolled in substance use disorder treatment. Reduces stigma associated with mental health concerns and provide additional support or referrals	Adolescents 12 to 17 years old with substance use disorder and other drug-induced problems	• Non-residential outpatient substance use disorder treatment and recovery services	McAlister Institute for Treatment and Education Teen Recovery Center 3923 Waring Rd. Suite D Oceanside, CA 92056 (760) 726-4451	5
CO-02	North County Serenity House	Women and Perinatal Residential SUD Treatment	Supports integrated treatment of co-occurring disorder issues for those enrolled in substance use disorder treatment. Reduces stigma associated with mental health concerns and provide additional support or referrals	Pregnant or parenting females	• Individual, group, family, child therapy • Substance use disorder counseling • Rehabilitative services, skill building • Childcare • Case management	Health Right 360 1735 Mission St. Suite 2051 San Francisco, CA 94103 (415) 762-1558	All
CO-02	North Inland Regional Recovery Center	Non-residential substance use disorder treatment and recovery services	To assist individuals to become and remain free of substance use disorder. For co-occurring clients, the goal is to 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 lifestlye	Adults with substance use disorder including co-occurring disorders	• Screening for mental health disorders; linkage to mental health services if indicated	North Inland RRC 200 E. Washington Ave. Suite 100 Escondido, CA 92025 (760) 741-7708	2, 3, 5
CO-02	North Inland Teen Recovery Center	Non-residential outpatient substance use disorder treatment and recovery services	Supports integrated treatment of co-occurring disorder issues for those enrolled in substance use disorder treatment. Reduces stigma associated with mental health concerns and provide additional support or referrals	Adolescents 12 to 17 years old with substance use disorder and other drug-induced problems	• Non-residential outpatient substance use disorder treatment and recovery services	Mental Health Systems Inc. 508 North Mission Ave. Suites 104 & 105 Escondido, CA 92025	3

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CO-02	North Inland Women and Adolescent Recovery Center	Women and Perinatal SUD Treatment	Supports integrated treatment of co-occurring disorder issues for those enrolled in substance use disorder treatment. Reduces stigma associated with mental health concerns and provide additional support or referrals	Pregnant or parenting females	• Individual, group, family therapy • Substance use disorder counseling • Rehabilitative services, skill building • Childcare	McAlister Institute for Treatment and Education 1400 North Johnson Ave. Suite 101 El Cajon, CA 92020 (619) 442-2012	2, 3, 5
CO-02	Parent Care Central	Women and Perinatal SUD Treatment	Supports integrated treatment of co-occurring disorder issues for those enrolled in substance use disorder treatment. Reduces stigma associated with mental health concerns and provide additional support or referrals	Pregnant or parenting females	• Individual, group, family therapy • Substance use disorder counseling • Rehabilitative services, skill building • Childcare	Vista Hill Foundation 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5121	4
CO-02	Parent Care East	Women and Perinatal SUD Treatment	Supports integrated treatment of co-occurring disorder issues for those enrolled in substance use disorder treatment. Reduces stigma associated with mental health concerns and provide additional support or referrals	Pregnant or parenting females	• Individual, group, family therapy • Substance use disorder counseling • Rehabilitative services, skill building • Childcare	Vista Hill Foundation 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5121	2
CO-02	Rachel's Women's Center	Non-residential substance use disorder recovery services that are non-institutional and non-medical	Delivers a safe, non-threatening substance use disorder free environment for homeless women that supports and encourages recovery by providing supportive interventions that address both substance use disorder and mental health issues, and assists the clients' efforts to attain and maintain recovery	Substance use disorder recovery services in downtown San Diego to homeless women 18 years and older who are recovering from substance use disorder	• Non-residential services shall include educational groups, process groups, and recovery supportive activities. Recovery services may include, but not necessarily be limited to: relapse prevention; recovery planning groups; self-help group participation • Mental health screening	Catholic Charities Homeless Women's Recovery Center 349 Cedar St. San Diego, CA 92101 (619) 236-9074	1, 4

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CO-02	Renaissance Treatment Center (includes detox and long term)	Provides substance use disorder residential treatment, recovery and ancillary services that are non-institutional and non-medical within licensed and certified residential programs, and non-institutional and non-medical detoxification services	Assists adults to become and remain free of substance use disorder problems and assist adults who are using, misusing, or abusing substances to withdraw from chemicals and to be oriented and referred to substance use disorder treatment or recovery programs, provide mental health screening and referrals and reduce stigma associated with mental health concerns	Adults 18 years and older with substance use disorder, including those who may have a co-occurring mental health disorder	• Residential adult substance use disorder social model recovery services and detoxification program, combining detoxification and pre-treatment/referral services to individuals as they withdraw from substance use • Mental health screening	Volunteers of America 2300 E. 7th St. National City, CA 91950 (619) 791-2730	All
CO-02	RRC South	Non-residential substance use disorder treatment and recovery service center	Ensures that adults experiencing co-occurring substance use disorder and mental health problems receive services that comprehensively address both disorders, so the individual may achieve substance use free lifestyle	18 years and older with substance use disorder, including those who may have co-occurring mental health disorder	• Rehabilitative services/skill building • Evidence-based treatment and recovery service incorporating both 12-step models (e.g., AA, NA) and non-12-step models (e.g., SMART Recovery, Rational Recovery, Secular Organizations for Sobriety) • Also, PC 1000 (Deferred Entry of Judgment) drug diversion services to adults • Mental health screening	McAlister Institute for Treatment and Education RRC South 1180 Third Ave. Suite C3 Chula Vista, CA 91911 (619) 691-8164	1
CO-02	San Diego Second Chance Program - Re-Entry Court	Provides intensive treatment services to offenders with long histories of drug use and criminal justice contacts, previous treatment failures, and high rates of health and social problems	To attain employment and stable housing, to substance use disorder free, complying with law and not committing new criminal offenses	Non-violent male and female offenders, with a history of substance use and co-occurring disorders, who have been referred to treatment by the Adult Drug Court team and accepted for intake in an environment free of substance use disorder	• Non-residential treatment, recovery, and ancillary services • Outpatient Drug-Free (ODF) treatment and intensive Day Care Habilitative (DCH) services	Second Chance 6145 Imperial Ave. San Diego, CA 92114 (619) 839-0931	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CO-02	Solutions for Recovery	Non-residential substance use disorder treatment and recovery service center	Assists individuals to become and remain free of substance use 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 substance use free lifestyle	Transition Age Youth, adults and older adults with substance use disorder and other drug-induced problems, including co-occurring mental health disorders. LGBTQ adults (as a priority). Adults who have any mental health disorder of sufficient severity, disability and persistence that it would interfere with the person participating successfully in a traditional program	• Contractor shall provide non-residential substance use disorder treatment and recovery services • 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, Secular Organizations for Sobriety • Mental health screening	Family Health Centers of San Diego 3928 Illinois St. San Diego, CA 92104 (619)515-2588	4
CO-02	South Bay Womens Recovery Center	Women and Perinatal SUD Treatment	Supports integrated treatment of co-occurring disorder issues for those enrolled in substance use disorder treatment. Reduces stigma associated with mental health concerns and provide additional support or referrals	Pregnant or parenting females	• Individual, group, family therapy • Substance use disorder counseling • Rehabilitative services, skill building • Childcare	McAlister Institute for Treatment and Education 400 North Johnson Ave. Suite 101 El Cajon, CA 92020 (619) 442-2012	1
CO-02	South Teen Recovery Center	Non-residential substance use disorder treatment and recovery services	Supports integrated treatment of co-occurring disorder issues for those enrolled in substance use disorder treatment. Reduces stigma associated with mental health concerns and provide additional support or referrals	Adolescents 12 to 17 years old with substance use disorder and other drug-induced problems	• Non-residential substance use disorder treatment and recovery services for adolescents	McAlister Institute for Treatment and Education Teen Recovery Center 629 3rd Ave. Ste. C Chula Vista, CA 91910 (619) 691-1045	1
CO-02	Stepping Stone of San Diego, Inc. Alcohol and Drug Residential AOD Treatment and Recovery Services	Residential treatment, recovery and ancillary services that are non-institutional and non-medical within licensed and certified residential programs	Reduces and/or eliminate the use of illicit drugs, abuse of prescription medications, and/or alcohol abuse to improve the overall health and social wellness of adults and HIV/AIDS positive adults; promotes participation in substance use disorder treatment and recovery programs; and if needed, fosters client capability to address medical needs related to HIV/AIDS and adhere to complex medication regimens	Adults with substance use disorders	• Residential substance use disorders structured program with treatment and/or recovery services available twenty-four hours per day, seven days a week	Stepping Stone Residential 3767 Central Ave. San Diego, CA 92105 (619) 278-0777	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CO-02	Substance Use Disorder Recovery Center	Non-residential substance use disorder treatment and recovery services for adults and Transition Age Youth	Supports integrated treatment of co-occurring disorder issues for those enrolled in substance use disorder treatment. Reduces stigma associated with mental health concerns and provide additional support or referrals	Asian and Pacific Islander adults 18 years and older	• Non-residential substance use disorder treatment • Family education • Mental health screening	UPAC 3288 El Cajon Blvd. Suites 3,6,10,11,12 & 13 San Diego, CA 92104 (619) 521-5720	4
CO-02	Teen Recovery Center - East	Non-residential outpatient substance use disorder treatment and recovery services	Supports integrated treatment of co-occurring disorder issues for those enrolled in substance use disorder treatment. Reduces stigma associated with mental health concerns and provide additional support or referrals	Adolescents 12 to 17 years old with substance use disorder and other drug-induced problems	• Non-residential substance use disorder treatment and recovery services for adolescents	McAlister Institute for Treatment and Education Teen Recovery Center 7800 University Ave. Suite A1 La Mesa, CA 91942 (619) 465-4349	2
CO-02	The Fellowship Center	Provides 24 hour social model recovery services that are non-institutional and non-medical within state-licensed and -certified residential facilities to individuals with substance use disorder	Assists adult males to become and remain free of substance use disorder and other drug problems	Adult/older adult men who are 18 years and older with a primary substance use disorder problem other than tobacco or ordinary caffeine containing beverages	• Educational groups, process groups, individual sessions • Recovery supportive activities. • Structured program available twenty-four hours per day, seven days a week to residents	Fellowship Center 737 East Grand Ave. Escondido, CA 92025 (760) 745-8478	All
CO-02	Women and Perinatal SUD Treatment	Women and Perinatal SUD Treatment	Supports integrated treatment of co-occurring disorder issues for those enrolled in substance use disorder treatment. Reduces stigma associated with mental health concerns and provide additional support or referrals	Pregnant or parenting females	• Individual, group, family therapy • Substance use disorder counseling • Rehabilitative services, skill building • Childcare	TBD	5
CO-02	Women and Perinatal SUD Treatment	Women and Perinatal SUD Treatment	Supports integrated treatment of co-occurring disorder issues for those enrolled in substance use disorder treatment. Reduces stigma associated with mental health concerns and provide additional support or referrals	Pregnant or parenting females	• Individual, group, family therapy • Substance use disorder counseling • Rehabilitative services, skill building • Childcare	McAlister Institute for Treatment and Education 1400 North Johnson Ave. Suite 101 El Cajon, CA 92020 (619) 442-2012	3, 4
CO-03	Next Steps	Provides comprehensive, peer-based care coordination, brief treatment and system navigation to adults with mental health and /or substance use disorder	Provides mental health screening and services to adults 18 years and older, including transition age youth and older adults with substance use disorder	Adults18 years and older	• On call either in person or via mobile devices • Screening tool for mental health and substance use disorder	NAMI SD 5095 Murphy Canyon Rd. Suite 320 San Diego, CA 92123 (858) 643-6580	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
DV-03	Alliance for Community Empowerment	Provides trauma informed, community centered, family driven and evidenced based Community Violence Response services. Central Region, but may serve clients outside the region Middle school aged boys and girls affected by violence	Increases in resilience; improvement in parenting knowledge; increases problem-solving and coping skills; reduces stigma and suicidal risk factors; reduces psycho-social impact of trauma	Middle school-aged youth	• Direct counseling, individual, and group interventions • Outreach, engagement, community education	Union of Pan Asian Communities 5348 University Ave. Suites 101 and 102 San Diego CA 92105 (619) 232-6454	4
DV-04	CSF Central & North Central Regions	Provides services and engagement with community resources and supports for families in order to assist in maintaining a safe home for children and reducing the effects of trauma exposure	Establishes a community safety net to ensure the safety and wellbeing 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 • STEP Training • Parent Partners	Social Advocates for Youth 8755 Aero Dr. Suite 100 San Diego, CA 92123 (858) 565-4148	4
DV-04	CSF East Region	Provides family preservation, family support, and family reunification services to children and families in the CWS system	Establishes a community safety net to ensure the safety and wellbeing 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 • STEP Training • Parent Partners	Home Start 5005 Texas St. Suite 203 San Diego, CA 92108 (619) 692-0727	2
DV-04	CSF - North Coastal/North Inland	Provides services and engagement with community resources and supports for families in order to assist in maintaining a safe home for children and reducing the effects of trauma exposure	Establishes a community safety net to ensure the safety and wellbeing 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 • STEP Training • Parent Partners	North County Lifeline 707 Oceanside Blvd. Oceanside, CA 92054 (760) 842-6250	5
DV-04	CSF - South Region	Provides services and engagement with community resources and supports for families in order to assist in maintaining a safe home for children and reducing the effects of trauma exposure	Establishes a community safety net to ensure the safety and wellbeing 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 • STEP Training • Parent Partners	South Bay Community Services 430 F St. Chula Vista, CA 91910 (619) 420-3620	1

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
EC-01	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	County-wide 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
FB-01	Kickstart	Provides Prevention and Early Intervention (PEI) services for persons10-25 years old who have emerging 'prodromal' symptoms of psychosis	Reduces incidence and severity of mental illness and increase awareness and usage of services	County-wide youth 10-25 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 Community Services, LLC 4281 Katella Ave. Suite 201 Los Alamitos, CA 90720 (562) 467-5532 6160 Mission Gorge Rd. Suite 400 San Diego, CA 92120 (858) 637-3030	All
NA-01	Indian Health Council, Inc.	PEI and substance use disorder treatment services to 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 San Diego region tribes; and qualified family members residing on reservations; All age groups; North region of San Diego County	• PEI and substance use disorder treatement 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
NA-01	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 PEI 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. Suite 105 San Diego, CA 92103 (619) 234-1525	4

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
NA-01	Southern Indian Health Council, Inc.	Provides PEI and substance use disorder 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 San Diego region tribes; and qualified family members residing on reservations; All age groups; South and East regions of San Diego County	• PEI and substance use disorder treatement 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
NA-01	Sycuan Medical/Dental Center	Provides specialized culturally appropriate behavioral health Prevention and Early Intervention (PEI) services to the Sycuan tribal community	Reduces ethnic disparities in service access and use. Increases access to care	American Indians; Alaska Natives; tribal members of South and East San Diego region tribes; and qualified family members residing on reservations; All age groups	• Provides specialized culturally appropriate behavioral health PEI services	Sycuan Band of Kumeyaay Nation 5442 Sycuan Rd. El Cajon, CA 92019 (619) 445-0707 ext.114	2
OA-01	Elder Multicultural Access & Support Services (EMASS)	Provides outreach and support to older adults, especially non-Caucasian/non-English speaking	Reduces ethnic disparities in service access and use. Increases access to care	Multi-cultural 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 525 14th St. Suite 200 San Diego, CA 92101 (619) 238-1783 ext.30	All
OA-02	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	Increases 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 525 14th St. Suite 200 San Diego, CA 92101 (619) 238-1783 ext.30	1, 4, 5
OA-06	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	Reduces incidence of mental health concerns in caregivers of Alzheimer's patients. Improves the quality of well-being for caregivers and families. Provides services to an underserved/unserved population	Adult Caregivers	• Outreach • Information dissemination • Early intervention • Education	Southern Caregiver Resource Center 3675 Ruffin Rd. San Diego, CA 92123 (858) 268-4432	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
PS-01	Breaking Down Barriers & Father2Child	Conducts outreach and engagement to ethnic and non-ethnic groups throughout the county. Father2Child is a parenting program for African American fathers/caregivers in southeastern San Diego	Reduces mental health stigma to culturally diverse, un-served and underserved populations	Unserved and underserved populations; Latino; Native American; African; 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	Mental Health Association of San Diego County 4069 30th St. San Diego, CA 92104 (619) 543-0412 ext.102	All
PS-01	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	Provides 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	NAMI San Diego 5095 Murphy Canyon Rd. Suite 320 San Diego, CA 92123 (858) 634-6597	All
PS-01	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	Provides county-wide community-based mental health literacy education and training services	Adults and 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
PS-01	Suicide Prevention & Stigma Reduction Media Campaign	County-wide media campaign geared towards suicide prevention and stigma discrimination, a suicide prevention action council to increase public awareness	Prevents suicide and reduce stigma and discrimination experienced by individuals with mental illness and their families. Increases awareness of available mental health services	County-wide individuals with mental illness; families of individuals with mental illness; general public	• Public media campaign to education and promote mental health concerns • Print, radio, and TV ads • Printed materials	Civilian Inc. 170 Laurel St. San Diego, CA 92101 (619) 243-2290	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
PS-01	Suicide Prevention Action Plan	Provides facilitation of the San Diego Suicide Prevention Council to increase public awareness and understanding of suicide prevention strategies	Provides 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	Community Health Improvement Partners 5095 Murphy Canyon Rd. Suite 105 San Diego, CA 92123 (858) 609-7974	All
PS-01	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	Employment is an essential element of comprehensive mental health services for adults with serious mental illness (SMI). Supported Employment is a key strategy for meeting both the employment and service needs of adults with SMI and the MHSA target populations. These services improves access to employment opportunities for adults with SMI	Service providers, employers, agencies, government organizations and other stakeholders	• Promote employment opportunities for adults with serious mental illness	San Diego Workforce Partnership, Inc. 3910 University Ave. Suite 400 San Diego, CA 92105 (619) 228-2952	All
RC-01	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	Increases access to and usage of services	Adults, Older Adults, Children and Transition Age Youth	• Assessment • Brief intervention • Education • Mobile outreach	Vista Hill Foundation 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5122	All
RE-01	CHIP Independent Living Association (ILA)	Creates an Independent Living Facility (ILA) Association with voluntary membership	Promotes the highest quality home environments for adults with severe mental illness	ILA operators, individuals, families, discharge planners and care coordination who are seeking quality housing resources	• Brief intervention	Community Health Improvement Partners 5095 Murphy Canyon Rd. Suite 105 San Diego, CA 92123 (858) 609-7974	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
SA-01	Project In-Reach	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	Reduces recidivism, diminish impact of untreated health, mental health and/or substance use disorder, prepare for re-entry into the community, and ensure successful linkage between in-jail programs and community aftercare	The program is focused on serving 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	• Pre- and-post-release case management, • Pre-release evidence based cognitive behavioral therapy (CBT) • Group interventions • Peer support • Post service linkages and follow up and transportation	NHA Project In Reach 286 Euclid Ave. Suite 207 San Diego, CA 92114 (619) 684-9065	All
SA-01	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.	Utilizing the Incredible Years evidenced based practice offer: • Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	San Diego Unified School District School Based PEI Central and North Central 4487 Oregon Street San Diego CA 92116	3, 4
SA-01	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.	Utilizing the Incredible Years evidenced based practice offer: • Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	San Diego Unified School District School Based PEI Central and Southeastern 4487 Oregon Street San Diego CA 92116	4
SA-01	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.	Utilizing the Incredible Years evidenced based practice offer: • Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement • assimilation groups for refugee children/parents. • Community linkage/referrals • Outreach and engagement	San Diego Youth Services School Based PEI East 3845 Spring Drive Spring Valley, CA 91977	2

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
SA-01	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	Utilizing the Incredible Years evidenced based practice offer: • Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	Palomar Family Counseling Services School Based PEI North Coastal 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660	3
SA-01	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	Utilizing the Incredible Years evidenced based practice offer: • Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	Vista Hill Foundation School Based PEI North Inland 1029 N. Broadway Escondido, CA 92026	5
SA-01	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	Utilizing the Incredible Years evidenced based practice offer: • Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	South Bay Community Services School Based PEI South 430 F St. Chula Vista, CA 91910 (619) 420-3620	1
SA-02	HERE Now	Provides school based suicide prevention education and intervention services to middle school, high school, and Transition Age Youth	Reduces suicides and the negative impact of suicide in schools. Increases education of education 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
VF-01	Courage to Call	Provides confidential, peer-staffed outreach, education, referral and support services to the Veteran community & families and its service providers	Increases awareness of the prevalence of mental illness in this community. Reduces mental health risk factors 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 • Support hotline	Mental Health Systems, Inc. 9445 Farnham St. Suite 100 San Diego, CA 02123 (858) 636-3604	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
INN-11	KidSTART Caregiver Connection to Treatment	Supports the mental health of the caregivers of young children to increase the mental health and support of families	The goal is to lead to improved access to mental health services for unserved and underserved caregivers which will consequently lead to improved outcomes for the children whose caregivers become engaged in their own care	Caregivers of children ages 0-5	• Care coordination • Link caregivers to their own services • Clinical groups specific to caregiver needs	Rady KidStart Central 3665 Kearny Villa Rd. Suite 500 San Diego, CA 92123 (858) 966-5990 Rady KidStart North 2204 El Camino Real Suite 102 Oceanside, CA 92054 (760) 967-7082 Rady KidStart South 333 H. St #3010 Chula Vista CA 91910 (619) 420-5611	All
INN-12	Family Therapy Participation Enhancement - Crossroads	Utilizes parent partners to focus on increasing caregiver participation in family therapy. Emphasis on teaching the caregiver the benefit of active engagement in treatment process and addressing barriers on individualized levels	The goal is to clarify, teach, and motivate the caregiver of the value of their involvement in treatment and how it will directly support the success and outcome of the family unit	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance (SED) criteria	• Outreach and engagement of caregivers in family therapy via a parent partner • Motivational Interviewing	Community Research Foundation Crossroads Family Center 1679 E. Main St. Suite 102 El Cajon, CA 92021 (619) 441-1907	2
INN-12	Family Therapy Participation Enhancement	Utilize parent partners to focus on increasing caregiver participation in family therapy. Emphasis on teaching the caregiver the benefit of active engagement in treatment process and addressing barriers on individualized levels	The goal is to clarify, teach, and motivate the caregiver of the value of their involvement in treatment and how it will directly support the success and outcome of the family unit	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance (SED) criteria	• Outreach and engagement of caregivers in family therapy via a parent partner • Motivational Interviewing	Community Research Foundation Nueva Vista Family Services 1161 Bay Blvd. Suite B Chula Vista, CA 91911 (619) 585-7686	1
INN-12	Family Therapy Participation Enhancement	Utilizes parent partners to focus on increasing caregiver participation in family therapy. Emphasis on teaching the caregiver the benefit of active engagement in treatment process and addressing barriers on individualized levels	The goal is to clarify, teach, and motivate the caregiver of the value of their involvement in treatment and how it will directly support the success and outcome of the family unit	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance (SED) criteria	• Outreach and engagement of caregivers in family therapy via a parent partner • Motivational Interviewing	Community Research Foundation Mobile Adolescent Services Team 1202 Morena Blvd. Suite 100 San Diego, CA 92110 (619) 398-3261	All
INN-12	Family Therapy Participation Enhancement	Utilizes parent partners to focus on increasing caregiver participation in family therapy. Emphasis on teaching the caregiver the benefit of active engagement in treatment process and addressing barriers on individualized levels	The goal is to clarify, teach, and motivate the caregiver of the value of their involvement in treatment and how it will directly support the success and outcome of the family unit	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance (SED) criteria	• Outreach and engagement of caregivers in family therapy via a parent partner • Motivational Interviewing	North County Lifeline Oceanside 707 Oceanside Blvd. Oceanside, CA 92054 (760) 757-0118 North County Lifeline Vista 200 Michigan Ave. Vista, CA 92084 (760) 726-4900	3, 5

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
INN-12	Family Therapy Participation Enhancement	Utilizes parent partners to focus on increasing caregiver participation in family therapy. Emphasis on teaching the caregiver the benefit of active engagement in treatment process and addressing barriers on individualized levels	The goal is to clarify, teach, and motivate the caregiver of the value of their involvement in treatment and how it will directly support the success and outcome of the family unit	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance (SED) criteria	• Outreach and engagement of caregivers in family therapy via a parent partner • Motivational Interviewing	Vista Hill Foundation LAC-Escondido 1029 N. Broadway Ave. Escondido, CA 92026 (760) 489-4126 Vista Hill Foundation LAC-Ramona 1012 Main St. Suite 101 Ramona, CA 92065 (760) 788-9724	2, 3, 5
INN-12	Family Therapy Participation Enhancement	Utilizes parent partners to focus on increasing caregiver participation in family therapy. Emphasis on teaching the caregiver the benefit of active engagement in treatment process and addressing barriers on individualized levels	The goal is to clarify, teach, and motivate the caregiver of the value of their involvement in treatment and how it will directly support the success and outcome of the family unit	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance (SED) criteria	• Outreach and engagement of caregivers in family therapy via a parent partner • Motivational Interviewing	Family Health Centers Community Circle: Spring Valley 3845 Spring Dr. Spring Valley, CA 91977 (619) 515-2380	2
INN-13	Faith-Based Initiative - Faith Based Academy	Design, develop and implement a Faith Based Academy.	Develop an educational curriculum and joint training that includes material to address faith/spirituality principles and values, wellness, mental health conditions, and resource information to faith communities and behavioral health providers in the North Inland region.	Faith leaders, behavioral health providers and members of congregations and community	• Education and Training	Interfaith Community Services 550 West Washington Ave. Escondido, CA 92025 (760) 489-6380	2,3,4,5
INN-13	Faith-Based Initiative - Faith Based Academy	Design, develop and implement a Faith Based Academy.	Develop an educational curriculum and joint training that includes material to address faith/spirituality principles and values, wellness, mental health conditions, and resource information to faith communities and behavioral health providers in the Central region.	Faith leaders, behavioral health providers and members of congregations and community	• Education and Training	TBD	1, 2, 4
INN-13	Faith-Based Initiative - Community Education	Provides faith-based mental health community education in North Inland region	Collaborates and participates with identified Faith Based and Behavioral Health Champions from Faith Based Academies. To facilitate community education presentations to faith communities and behavioral health providers with HHSA North Island region	Faith leaders, behavioral health providers and members of congregations and community	• Community education	NAMI San Diego 5095 Murphy Canyon Rd. Suite 320 San Diego, CA 92123 (858) 634-6580	2, 3, 5
INN-13	Faith-Based Initiative - Community Education	Provides outreach, engagement, training and community education	Collaborates and participates with identified Faith Based and Behavioral Health Champions from Faith-Based Academies. Facilitates community education presentations to faith communities and behavioral health providers with HHSA Central region	Children, Transition Age Youth, Adults/ Older Adults in Central Region	• Outreach, engagement and training • Community Education	Total Deliverance Worship PO Box 1698 Spring Valley, CA 91979	1, 2, 4

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
INN-13	Faith-Based Initiative - Crisis Response Team	Provides faith-based mental health crisis response in the Central Region	Mobile community-based program that pairs licensed mental health clinicians and clergy to respond to individual and family crisis situations 24/7	Families in the Central region, with a focus on African American and Latino communities	• Crisis response	Total Deliverance Worship Center 7373 University Ave. Suite 201 La Mesa, CA 91942 (619) 825-3930	1, 2, 4
INN-13	Faith-Based Initiative - Wellness and Health Inreach Ministry	Implement a Wellness and Mental Health In-reach Ministry that focuses on Adults diagnosed with a Serious Mental Illness while in jail	Provide an jail In-reach program for adults with a Serious Mental Illness that includes spiritual support, mental and physical health wellness, counseling on untreated mental illness and co-occurring disorders, linkage to resources for and assistance with re-integration back into the community, and support services consistent with pastoral counseling and the individual's faith of choice.	Incarcerated adults diagnosed with a serious mental illness in the North region	• Mental health and co-occuring disorders support and counseling. • Spiritual support • Community re-integration	Training Center Ephesians 525 Grand Avenue Spring Valley, CA 91977	2,3,4,5
INN-13	Faith-Based Initiative - Wellness and Health Ministry	Implement a Wellness and Mental Health In-reach Ministry that focuses on Adults diagnosed with a Serious Mental Illness while in jail	Provide an jail In-reach program for adults with a Serious Mental Illness that includes spiritual support, mental and physical health wellness, counseling on untreated mental illness and co-occurring disorders, linkage to resources for and assistance with re-integration back into the community, and support services consistent with pastoral counseling and the individual's faith of choice.	Incarcerated adults diagnosed with a serious mental illness in the Central region	• Mental health and co-occuring disorders support and counseling. • Spiritual support • Community re-integration	Training Center Ephesians 525 Grand Avenue Spring Valley, CA 91977	1, 2, 4
INN-14	Supported Employment Initiative - Ramp Up 2 Work	Engages and retains employment opportunities for Transition Age Youth and Adults/ Older Adults with serious mental illness in the behavioral health system through an enhanced array of supported and competitive employment options	To expand employment opportunities for Transition Age Youth and Adults/Older Adults with a serious mental illness and to promote self-determination and empowerment. The program helps clients overcome barriers to employment	Transition Age Youth, Adults/Older Adults who have a serious mental illness	• Client functional assessment • Employment reediness assessment • Job coaches • Computer skills support	UPAC 1031 25th St. San Diego, CA 92102 (619) 232-6454	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
INN-15	Peer Assisted Transition	Provides peer specialist coaching, incorporating shared decision-making and active social supports, to increase the depth and breadth of services to person diagnosed with serious mental illness who use acute, crisis-oriented mental health services but are not effectively connected to community resources. Services will be focused on those persons who, in addition to needing to use hospital and/or crisis house services, have a limited social support network and are most likely to not be effectively connected with relevant services	Increases depth and breadth of services to persons diagnosed with serious mental illness who use acute, crisis-oriented mental health services but are not effectively connected with community resources through the provision of peer specialist coaching incorporating shared decision-making and active social supports	Transition Age Youth, Adults/Older Adults in Central, North Coastal & North Inland regions	• Peer specialist coaching • Connecting to relevant services	NAMI San Diego 5095 Murphy Canyon Rd. Suite 320 San Diego, CA 92123 (858) 634-6586	All
INN-16	Urban Beats	Provides an artistic expression that includes the use of multiple models of artistic expression including visual arts, spoken word, music, videos and performances and social media created and developed by Transition Age Youth	Increase the engagement and retention rates in mental health treatment of serious emotional disturbance and serious mental illness and at risk Transition Age Youth by incorporating a Transition Age Youth focused recovery message into an artistic expression and social marketing	Transition Age Youth who are clients of the mental health system with serious emotional disturbance/serious mental illness or at-risk of mental health challenges	• Develop youth leaders within TAY community • Increase access to services • Whole health and prevention services	Pathways Community Services 3330 Market St. San Diego, CA 92101 (858) 227-9051	All
INN-17	Cognitive Rehabilitation and Exposure Sorting Therapy (CREST) mobile hoarding unts (formerly IMHIP)	Diminishes long term hoarding behaviors in Older Adults	Improves health, safety, quality of life, and housing stability through provision of comprehensive hoarding treatment	Older Adults 60 years and older with hoarding disorder and a serious mental illness in the Central, South, and North Regions	• Community outreach and engagement • In-home therapy • Family support	Regents of the University of California, UCSD 200 West Arbor Dr. San Diego, CA 92103 (619) 471-9396	All
INN-18	TBD	Identifies at-risk peripartum women for engagement and provides services for women and spouses	Reduces 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	Pending MHSOAC approval	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
INN-19	TBD	Provides post psychiatric emergency services follow-up treatment and stabilization via electronic devices for tele-therapy	Prevents re-hospitalization and psychiatric emergency services with follow up mental health services for successful re-integration following a psychiatric emergency	Youth and adults	• Follow-up mental health treatment and stabilization via tele-therapy • Case Management • Digital tele-therapy training and engagement • Outreach and engagement	Pending MHSOAC approval	All
INN-20	Roaming Outpatient Access Mobile Services (ROAM)	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 and North Inland Regions	• Outreach and engagement • Telemedicine • Counseling and clinic services • Telemedicine • Traditional interventions via cultural brokers	Program approved May 25, 2017; RFP Pending.	2, 5
INN-21	Recuperative Services Treatment (ReST)	Provides post-institutionalization recuperative residential services, includes wrap-around services, case management, and permanent housing help	Prevents 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	Program approved May 25, 2017; RFP Pending.	1, 2, 4
INN-22	TBD	Provides ongoing medication management for children and youth with complex psychiatric pharmacological needs	Promote stabilization by providing accessible follow up for complex psychiatric pharmacological needs	Children and youth up to age 21	• Medication management • Psychiatric consultation • Outreach and engagement • Psycho-educational seminars and groups for families	Program approved May 25, 2017; RFP Pending.	All

Work Plan	Program	Program Name & Contract Agency	Program Description	Contract Information	Districts
WET-02	Training and Technical Assistance	Regional Training Center (RTC)	Provides administrative and fiscal training support services to HHSA 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 HHSA 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
WET-03	Public Mental Health Academy	San Diego Community College District	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 AA and/or BA 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
WET-03	RI International (aka Recovery Innovations, Inc.)	Consumer/Family Academy, TAY/Adult/Older Adult Peer Specialist Training	Provide recovery-oriented, Peer Specialist training to adults aged 18 (eighteen) 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 provides	Recovery Innovations, Inc. 2701 North 16th St. Phoenix, Arizona 85006 (602) 650-1212	All
WET-04	Residency, Internship Programs; Community Psychiatry Fellowship	Regents of the University of California, UCSD Community Psychiatry Fellowships	Programs are for physicians- one for adult psychiatry residents and fellows and the second for child and adolescent psychiatry residents and fellows. Programs foster the development of leaders in Community Psychiatry and provide exposure to the unique challenges and opportunities, 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

Work Plan	Program Name	Program Description	Population Focus	Services Offered	Contact Information	Districts
SD-3	Personal Health Record	The Personal Health Record embedded in the InteliChart Patient Portal enables patients to both securely view and update their records in a timely manner	All ages	• PHR is constructed from patients existing behavioral health medical record. InteliChart provides and supports mobile apps that enable patients to make appointments, view lab results, and securely communicate with their healthcare providers conveniently using mobile technology	TBD	All
SD-5	Telepsychiatry	Provide technological support for telemedicine at Heartland Bio-Psychosocial Rehabilitation WRC	Adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder. Includes Probation-funded AB 109 component	• Clinic services supported: Outpatient mental health clinic providing 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	Community Research Foundation, Heartland Center 460 N. Magnolia Ave. El Cajon, CA 92020 (619) 440-5133	2
SD-5	Telepsychiatry	Provide technological support for telemedicine at South Region Biopsychosocial Rehabilitation Wellness Recovery Center	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 AB109 component	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, recovery, and SBCM services to adults 18 years and older Transition Age Youth & AB109 who have serious mental illness, including those who may have a co-occurring substance use disorder	Community Research Foundation, Maria Sardiñas Wellness & Recovery Center 1465 30th St. Suite K San Diego, CA 92154 (619) 428-1000	1
SD-5	Telepsychiatry	Provide technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	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, AB109	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, recovery, and SBCM services to adults 18 years and older	Community Research Foundation, South Bay Guidance Wellness and Recovery Center 835 3rd Ave. Suite C Chula Vista, CA 91911 (619) 427-4661	1

Work Plan	Program Name	Program Description	Population Focus	Services Offered	Contact Information	Districts
SD-5	Telepsychiatry	Provides technological support for telemedicine at UPAC	Monolingual and/or limited English proficient Asian/Pacific Islander adults 18 years and older with a serious mental illness who may have a co-occurring substance use disorder	• Clinic services supported: Outpatient case management, vocational support services for indigent clients with a serious mental illness	UPAC Mid-City BPSR 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 (619) 268-0244	1, 4
SD-5	Telepsychiatry	Provide technological support for telemedicine at North Central Region Adult/Older Adult Bio-Psychosocial Rehabilitation Wellness Recovery Center	Adults 18 years and older who have a SMI including those with co-occurring and Medi-Cal eligible or indigent	• Clinic services supported: Outpatient mental health rehabilitation and recovery services, an urgent walk-in component, case management; and long-term vocational support	CRF Douglas Young Center 10717 Camino Ruiz Suite 207 San Diego, CA 92126 (858) 695-2211	3, 4
SD-5	Telepsychiatry	Provides technological support for telemedicine at Project Enable	Transition Age Youth, Adults and Older Adults 60 years and older including those who may have a co-occurring substance use disorder	• Clinic services supported: Stabilization and recovery services with the expectation that with treatment, clients will effectively recover and graduate from the program	Neighborhood House Association 286 Euclid Ave. Suite 102 San Diego, CA 92114 (619) 266-9400	All
SD-5	Telepsychiatry	Provide technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, and recovery services	Southeast Mental Health Center 3177 Ocean View Blvd. San Diego, CA 92113 (619) 595-4400	1, 4

Work Plan	Program Name	Program Description	Population Focus	Services Offered	Contact Information	Districts
SD-5	Telepsychiatry	Provide technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Transition Age Youth, Adults and Older Adults who have a serious manta illness, including those who may have a co-occurring substance use disorder	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults 18 years and older	MHS, Inc. North Inland Mental Health Center 125 W. Mission Ave. Suite 103 Escondido, CA 92025 (760) 747-3424 Kinesis Wellness & Recovery Center 474 W. Vermont Ave. Suite 101 Escondido, CA 92025 (760) 480-2255 Fallbrook Satellite 1328 S. Mission Rd. Fallbrook, CA 92028 (760) 451-4720 Ramona Satellite 1521 Main St. Ramona, CA 92065 (760) 736-2429	3, 5
SD-5	Telepsychiatry	Provide technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Transition Age Youth, Adults and Older Adults who have a serious mental illness, including those who may have a co-occurring substance use disorder	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults 18 years and older	MHS, Inc. North Coastal Mental Health Center 1701 Mission Ave. Oceanside, CA 92058 (760) 967-4475 MHS, Inc. Vista 550 West Vista Way Suite 407 Vista, CA 92083 (760) 758-1092	4
SD-5	Telepsychiatry	Provide technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Children, adults and older adults who are deaf or hard of hearing and who have a serious mental illness or substance use disorder	• Clinic services supported: Outpatient mental health services, case management and substance use disorder services are provided for deaf and hard of hearing adults	Deaf Community Services of San Diego Inc. 1545 Hotel Circle S. Suite 300 San Diego, CA 92108 (619) 398-2437	All

Work Plan	Program Name	Program Description	Population Focus	Services Offered	Contact Information	Districts
SD-5	Telepsychiatry	Provide technological support for telemedicine at an outpatient psychiatric medication services clinic	Children, Transition Age Youth, adults and older adults via telehealth technology	• Clinic services supported: Outpatient psychiatric medication services to consumers utilizing Telehealth practices and technology	Exodus Recovery, Inc. 524 W. Vista Way Vista, CA 92083 (760) 758-1150 1520 S. Escondido Blvd. Escondido, CA 92025 (760) 796-7760	All
SD-5	Telepsychiatry	Provide technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Adults 18 years and older who have a serious mental illness	• Clinic services supported: Walk-in outpatient mental health assessments and psychiatric consultation, medication management services; crisis intervention and case management brokerage	Community Research Foundation, Jane Westin Wellness & Recovery Center Walk In Services Assessment Center 1045 9th Ave. San Diego, CA 92101 (619) 235-2600	1, 4
SD-5	Telepsychiatry	Provide technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, and recovery services	East County Mental Health Center 1000 Broadway Suite 210 El Cajon, CA 92021 (619) 401-5500	2
SD-5	Telepsychiatry	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Adults 18 years and older who have a serious mental illness	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, and recovery services, including those who may have a co-occurring substance use disorder	North Central Mental Health Clinic 1250 Morena Blvd. San Diego, CA 92110 (619) 692-8750	4
SD-5	Telepsychiatry	Provide technological support for telemedicine for youth and children receiving outpatient mental health services	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance (SED) criteria	Utilizing telemedicine for psychiatry services by offering: • Video Conferencing • Secure email • Phone consultation.	Community Research Foundation Crossroads Family Center 1679 E. Main St. Suite 102 El Cajon, CA 92021 (619) 441-1907	2
SD-5	Telepsychiatry	Provides technological support for telemedicine at Douglas Young Youth and Family Services Outpatient Children's Mental Health Services	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance (SED) criteria	Utilizing telemedicine for psychiatry services by offering: • Video Conferencing • Secure email • Phone consultation.	Community Research Foundation 1202 Morena Blvd. Suite 300 San Diego, CA 92110 (619) 275-0822	3, 4

Work Plan	Program Name	Program Description	Population Focus	Services Offered	Contact Information	Districts
SD-5	Telepsychiatry	Provide technological support for telemedicine for youth and children receiving outpatient mental health services	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance (SED) criteria	Utilizing telemedicine for psychiatry services by offering: • Video Conferencing • Secure email • Phone consultation	Community Research Foundation Nueva Vista Family Services 1161 Bay Blvd. Suite B Chula Vista, CA 91911 (619) 585-7686	1
SD-5	Telepsychiatry	Provide technological support for telemedicine for youth and children receiving outpatient mental health services.	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance (SED) criteria	Utilizing telemedicine for psychiatry services by offering: • Video Conferencing • Secure email • Phone consultation	Community Research Foundation Mobile Adolescent Services Team 1202 Morena Blvd. Suite 100 San Diego, CA 92110 (619) 398-3261	All
SD-5	Telepsychiatry	Provide technological support for telemedicine at short-term, acute residential treatment clinics	Voluntary adults who have a serious mental illness/Co-Occurring Disorder experiencing a mental health crisis, in need of intensive, non-hospital intervention	• Clinic services supported: 24-hour, 7-day a week 365 day a year crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital for adults with acute and serious mental illness, including those who may have a co-occurring substance use conditions, and are residents of San Diego County	Vista Balboa 545 Laurel Ave. San Diego, CA 92101 (619) 233-4399 New Vistas 734 10th Ave. San Diego, CA 92101 (619) 239-4663 Halcyon 1664 Broadway El Cajon, CA 92021 (619) 579-8685 Turning Point 1738 S. Tremont St. Oceanside, CA 92054 (760) 439-2800 Jary Barreto 2865 Logan Ave. San Diego, CA 92113 (619) 232-4357 Del Sur (formerly Isis) 892 27th St. San Diego, CA 92154 (619) 575-4687	All

Work Plan	Program Name	Program Description	Population Focus	Services Offered	Contact Information	Districts
SD-5	Telepsychiatry	Provides technological support for telemedicine at Areta Crowell	Adults 18 years and older who have a serious mental illness	Clinic services supported: Outpatient mental health rehabilitation and recovery services, case management; and long-term vocational support, including those who may have a co-occurring substance use disorder	Community Research Foundation 1963 4th Ave. San Diego, CA 92101 (619) 233-3432	4
SD-5	Telepsychiatry	Provide technological support for telemedicine at Esperanza Crisis Center	Voluntary adults 18 years and older with acute and a serious mental illness including those who may have a co-occurring substance use disorder and are residents of San Diego County	Clinic services supported: Crisis residential services as an alternative to hospitalization or step down from acute in-patient care within a hospital, including those who may have a co-occurring substance use conditions	Community Research Foundation 490 N. Grape St. Escondido, CA 92025 (760) 975-9939	All
SD-6	Road Map into the Millennium	This project replaced the core information system used by virtually all providers in the extended system of care, including all clinical and billing information. The new Practice Management and Managed Care System replaces in their entirety the legacy applications that were in use	The main users of the system will be County of San Diego employees, County Service Providers, Administrative Support Organizations (ASO's) and Fee For Service Providers	• InSyst application – supported by Echo Management, Inc. and resides on VAX hardware. It is a client and service tracking and billing application that is used by CoSD and contract mental health providers to coordinate client care, perform required State reporting requirements and bill Medi-Cal and other payers; eCura application – supported by InfoMC and used for Managed Care. The end users are United Behavioral Health (UBH) Administrative Services Organization (ASO) employees	Cerner Corporation 2800 Rockcreek Pkwy. North Kansas City, MO 64117 (816) 201-1989	All

Work Plan	Program Name	Program Description	Population Focus	Services Offered	Contact Information	Districts
SD-8	Connect Well San Diego	Program identifies opportunities to aggregate data across the continuum of care from disparate systems, creating a longitudinal patient record containing information that supports programs such as decision support, quality measurement, and analytics for population management. The ConnectWell platform will be developed to create a Health Information Exchange to provide the means for this interoperability project	The primary users of the system will include County of San Diego employees, contracted service providers and the contracted Administrative Services Organization	• Creates a secure platform where System Users can work together across programs to serve a particular customer • Allows System Users to search for County and partner service providers – and even filter by language, location, etc. • Using modern technology to share information will help staff improve their ability to provide person-centered service	ConnectWellSD 1255 Imperial Ave. Suite 740 San Diego, CA 92101 (619) 338-2036	All
SD-9	Financial Management System	The Financial Management System will ensure operational efficiency and cost effectiveness in mental health administration by creating a centralized financial system capable of day-to-day budget management, year-to-date revenue and expenditure monitoring, contract tracking and business analytics tools, including standard reporting, dashboards and queries	The business areas and programs served including the following: Registration/Administration; Service Recording; Electronic Health Record; Medi-Cal Billing; Other Billing; Managed Care Functionality	• This system will streamline financial data collection and reporting, including potentially assisting with the annual MHSA Revenue & Expenditure Report (RER), maintain the integrity of data with system securities and prevent duplication of effort to ensure resources are fully maximized	Behavioral Health Services 3255 Camino del Rio S. San Diego, CA 92120 (619) 563-2700	All

Appendix D

Full Service Partnerships (FSP) Outcomes Report

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 2015-16***

What Is This?

Full Service Partnership (FSP) programs are comprehensive behavioral health programs which provide all necessary services and supports, including intensive services, to clients with a high level of need to enable them to live in their community. Services may include in-home and community-based intensive case management to provide support and assistance in obtaining such services as benefits for low-income families, health insurance, parent education, tutoring, mentoring, youth recreation, and leadership development. FSP programs may also assist with connections to resources such as physical health services, interpreter services, and acquisition of food, clothing, and school supplies.

Why Is This Important?

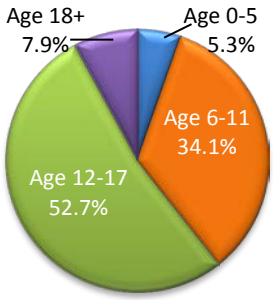
FSP programs support individuals and families, using a "whatever it takes" approach to establish stability and maintain engagement. The programs build on client strengths and assist in the development of abilities and skills so clients can become and remain successful. They help clients reach identified goals such as acquiring a primary care physician, increasing school attendance, improving academic performance, and reducing involvement with forensic services.

Who Are We Serving?

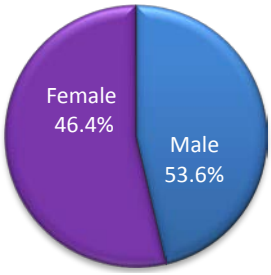
In Fiscal Year (FY) 2015-16, a total of 3,648 unduplicated clients received services through 18 FSP programs, a 21% increase from 3,016 FSP clients served in 16 FSP programs in FY 2014-15.

FSP Client Demographics and Diagnoses (N = 3,648)

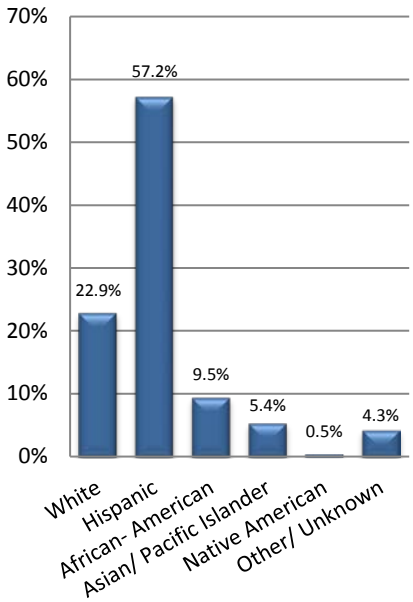
AGE



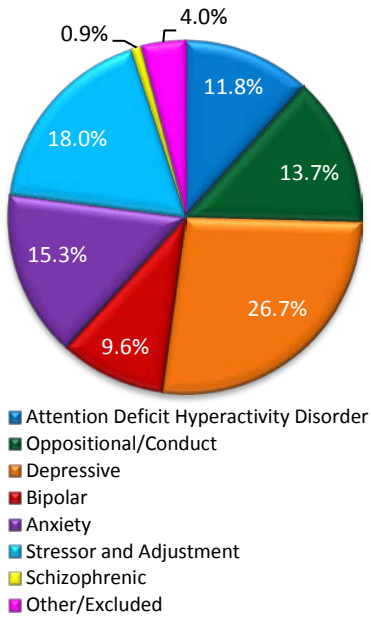
GENDER



RACE/ETHNICITY



PRIMARY DIAGNOSIS

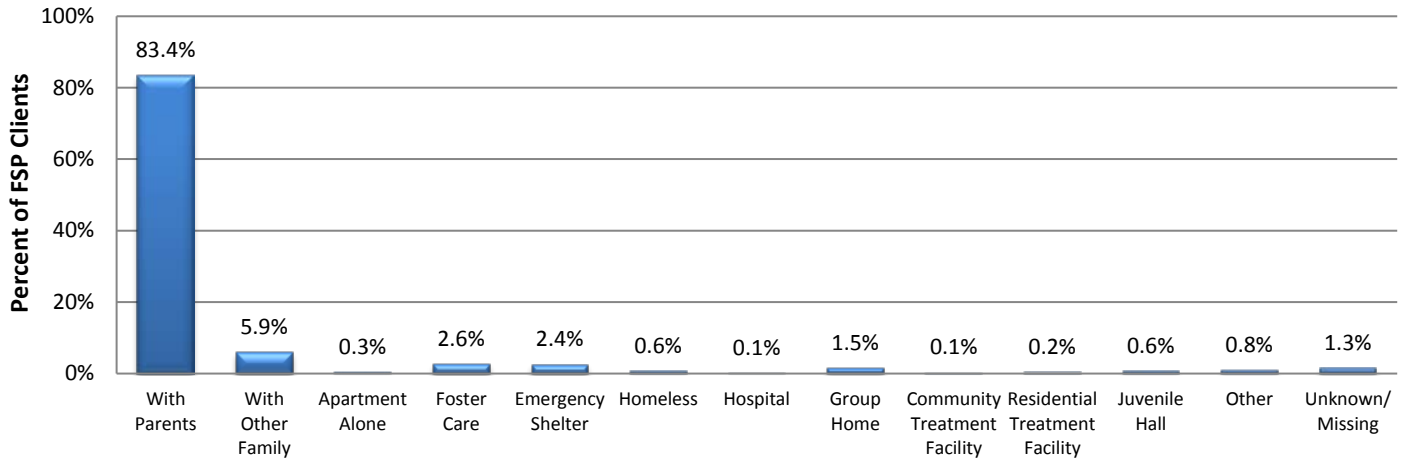


Who Are We Serving?

FSP providers collected client and outcomes data using the Department of Health Care Services (DHCS) Data Collection & Reporting System (DCR). Residential status and risk factors were entered for new clients to FSP programs in FY 2015-16. Referral sources were also entered; FSP referrals in order of frequency were as follows: school system (25%), family member (21%), primary care physician (13%), mental health facility (12%), social service agency (7%), self-referral (5%), other county agency (5%), Juvenile Hall (4%), acute psychiatric facility (2%), friend (1%), homeless shelter (<1%), emergency room (1%), or substance abuse facility (<1%). The remaining 4% were referred by an unknown or unspecified source.

Residential Status at Intake (n = 2,007)*

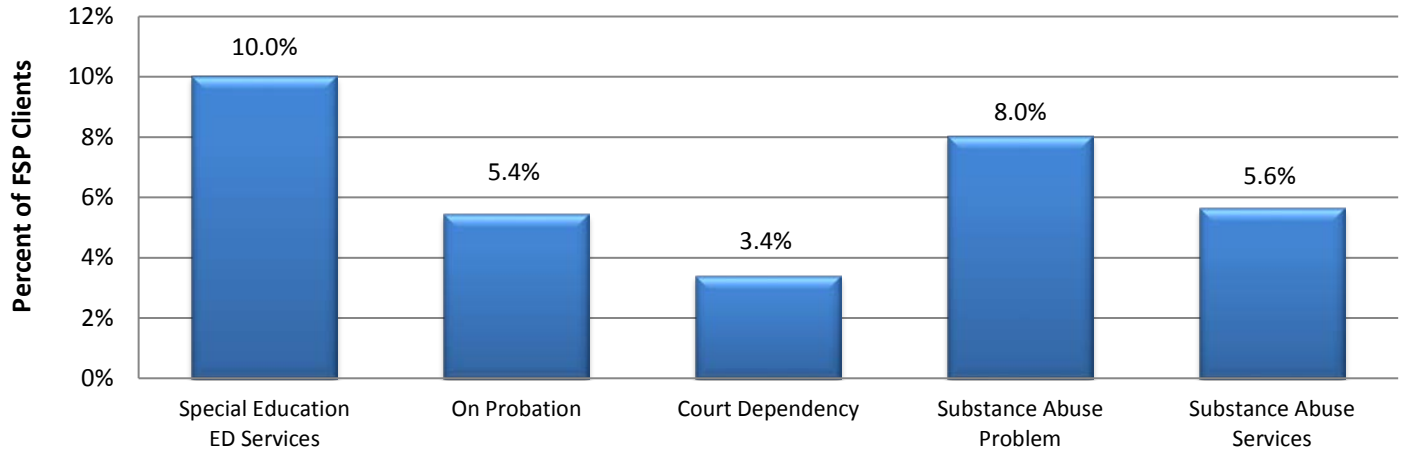
The majority of youth entering FSP programs were living with their parents.



**Clients with intake assessment in the DCR within FY 2015-16.*

Risk Factors at Intake (n = 2,007)*

The most prevalent risk factor for more intensive service use among youth entering FSP programs was related to Special Education—Emotionally Disturbed (ED) Services. 1,527 (76%) of clients had no risk factors identified at intake. Clients with identified risk factors may have had more than one risk factor endorsed.



**Clients with intake assessment in the DCR within FY 2015-16.*

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 2015-16, a total of 21 FSP clients had an arrest recorded in the DCR.

Inpatient and Emergency Services

Of the 3,648 unduplicated clients who received services from an FSP program in FY 2015-16, 107 (2.9%) had at least one inpatient (IP) episode and 102 (2.8%) had at least one Emergency Screening Unit (ESU) visit during the treatment episode.

Are Children Getting Better?

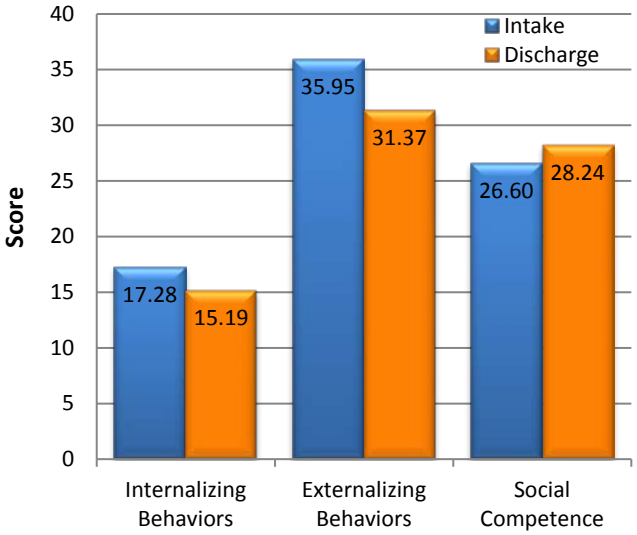
FSP providers collected outcomes data with the Child and Adolescent Measurement System (CAMS) and the Children's Functional Assessment Rating Scale (CFARS). Scores were analyzed for youth discharged from FSP services in FY 2015-16, who were in services at least three weeks (CFARS) or two months (CAMS) and had a maximum of two years between intake and discharge assessment, and who had both intake and discharge scores for all measure domains. Additionally, Personal Experience Screening Questionnaire (PESQ) scores were analyzed for youth discharged from FSP Substance Use Disorder (SUD) programs in FY 2015-16, who were in services for at least one month.

FSP CAMS Scores

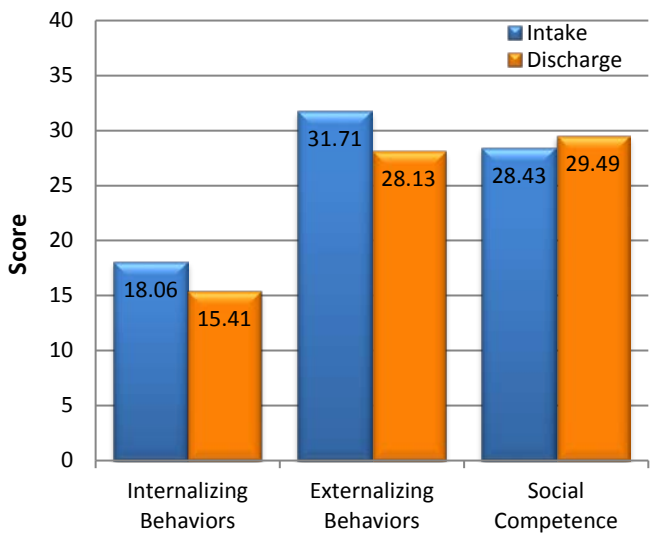
The CAMS measures a child's social competency, behavior and emotional problems; it is administered to all caregivers, and to youth ages 11 and older. A *decrease* on the Internalizing (e.g., depressive or anxiety disorders) and/or Externalizing (e.g., ADHD or oppositional disorders) CAMS score is considered an improvement. An *increase* in the Social Competence (e.g., personal responsibility and participation in activities) score is considered an improvement.

These CAMS results (n = 747 Parent/Caregiver CAMS; n = 470 Youth CAMS) revealed improvement in youth behavior and emotional problems following receipt of FSP services.

FSP Parent/Caregiver CAMS (n = 747)



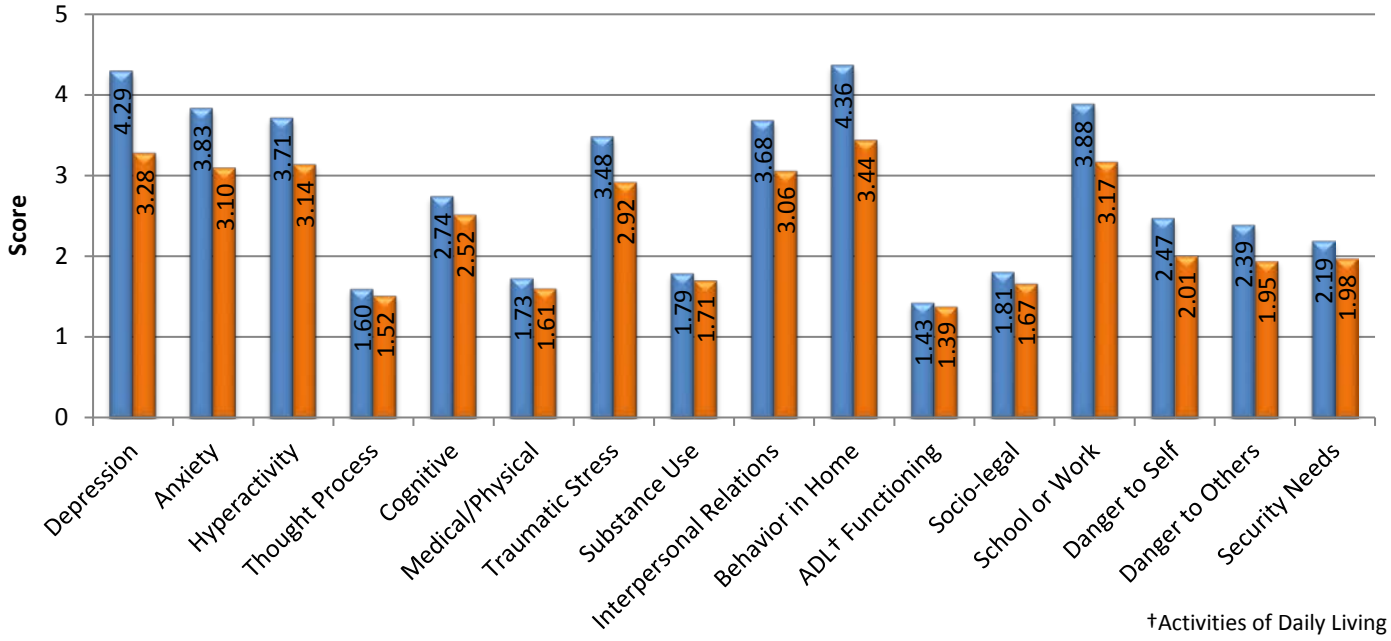
FSP Youth CAMS (n = 470)



Are Children Getting Better?

FSP CFARS Scores (n = 1,494)

The CFARS measures level of functioning on a scale of 1 to 9 and is completed by the client's clinician. A *decrease* on any CFARS item score is considered an improvement. CFARS data were available on 1,494 FSP clients in FY 2015-16 and revealed improvement in youth symptoms and behavior following receipt of FSP services.

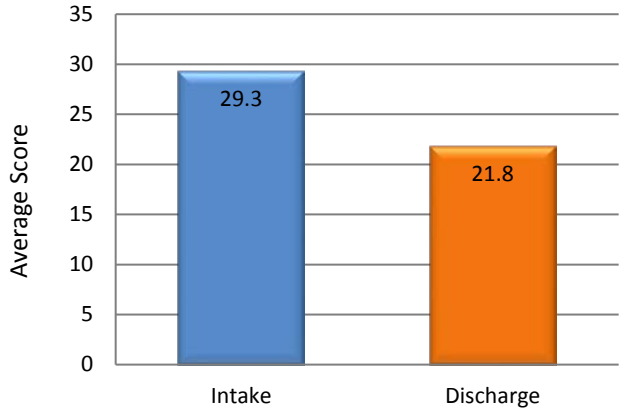


†Activities of Daily Living

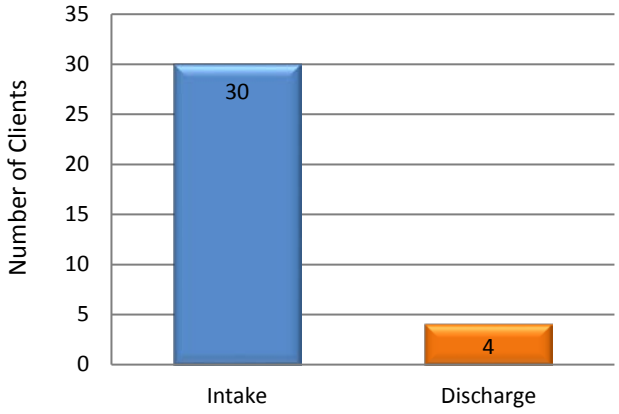
FSP PESQ Scores

The PESQ measures potential substance abuse problems and is administered to youth ages 12-18 by their Alcohol and Drug (AD) counselor; the PESQ is only administered at FSP programs which are augmented with a dedicated AD 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 88 discharged clients in FY 2015-16.

PESQ Severity Scale (n = 88)



PESQ Clinical Cutpoint

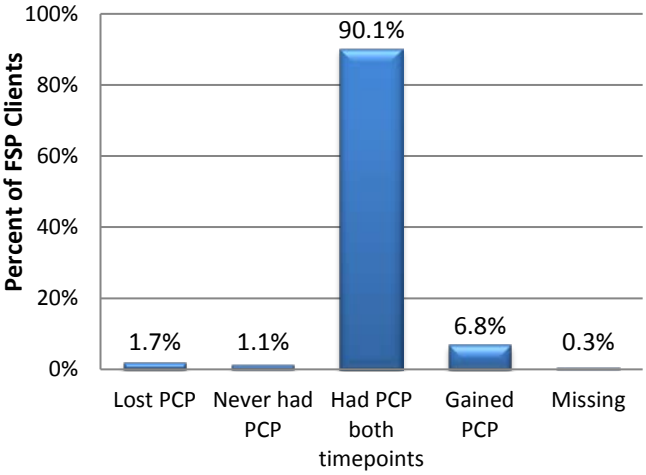


Are Children Getting Better?

FSP providers also collected client and outcomes data on primary care physician 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.

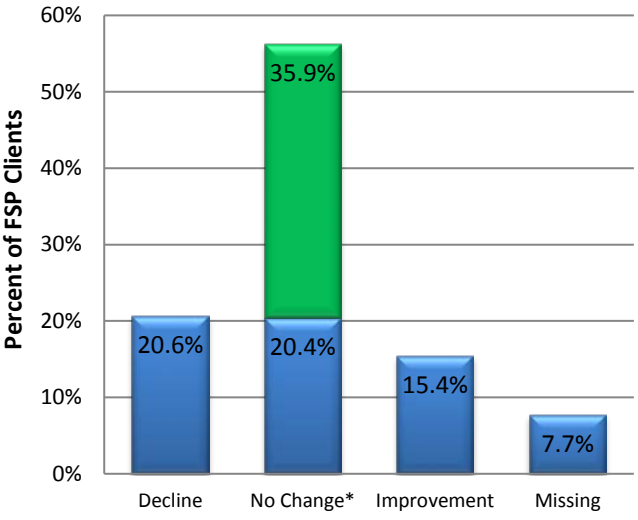
Primary Care Physician (PCP) Status (n = 1,949)

90% of FSP clients had and maintained a PCP.



School Attendance (n = 1,949)

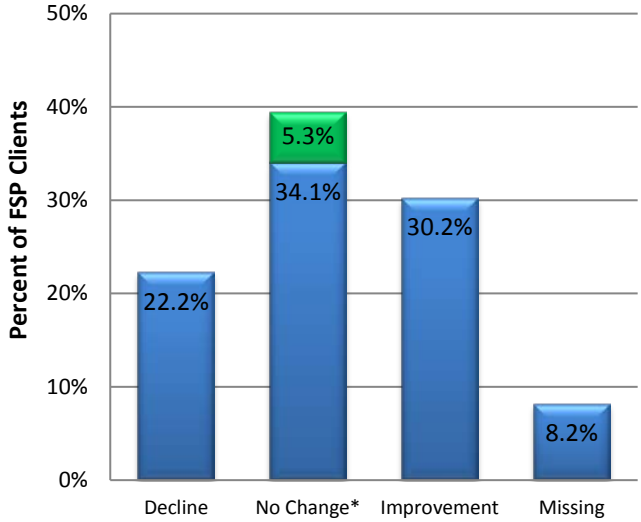
51% of FSP clients either improved (15%) or maintained excellent (36%) school attendance at follow-up assessment as compared to intake.



**Of the 56% of clients for whom no change was noted, 36% (green portion of bar) had consistently excellent attendance (intake and discharge assessments indicated most positive category for school attendance).*

Academic Performance (n = 1,949)

35% of FSP clients either improved (30%) or maintained excellent (5%) grades at follow-up assessment as compared to intake.



**Of the 39% of clients for whom no change was noted, 5% (green portion of bar) had consistently excellent grades (intake and discharge assessments indicated most positive category for school grades).*

What Does This Mean?

- County of San Diego Children, Youth & Families Behavioral Health Services FSP programs have continued to enroll more clients.
- Children and youth who receive treatment in FSP programs showed improvement in their mental health symptoms, according to client, parent, and clinician report.
- Treatment of youth by AD counselors at enhanced FSP programs was successful. On average, the severity of a client's problems decreased from intake to discharge. Furthermore, when comparing intake to discharge, there was a large reduction in the number of clients who scored above the clinical cutpoint on the PESQ.
- The majority of youth FSP clients had and maintained a PCP during their tenure in FSP programs.
- More than half of youth FSP clients improved or maintained excellent school attendance. Approximately one-third of youth FSP clients improved or maintained excellent grades. FSP programs should continue to work with schools to ensure their clients' mental health challenges do not inhibit their academic success.

Next Steps

- Seven additional FSP programs are being allocated beginning FY 2016-17.

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@ucsd.edu or 858-966-7703 x7141.

Appendix E

FSP Assertive Community Treatment (ACT) With MHSA Housing Funds Report

FSP ACT Teams with MHSA Housing Funds

Fiscal Year 2015-16 Report

Making a Difference in the Lives of Adults and Older Adults with Serious Mental Illness

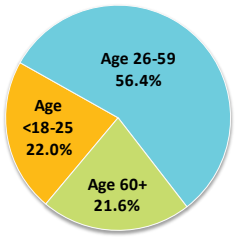
San Diego County Full Service Partnership (FSP) programs promote recovery and resilience through comprehensive, integrated, consumer-driven, strength-based care and a "whatever it takes," housing first approach. Targeted to help those clients with the most serious mental health needs, services are intensive, highly individualized, and focused on helping clients achieve long-lasting success and independence.

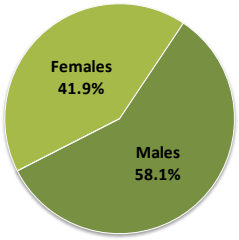
Full fidelity Assertive Community Treatment (ACT) teams—which include psychiatrists, nurses, mental health professionals, employment and housing specialists, peer specialists, and substance-abuse specialists—provide medication management, vocational services, substance abuse services, and other services to help clients sustain the highest level of functioning while remaining in the community.

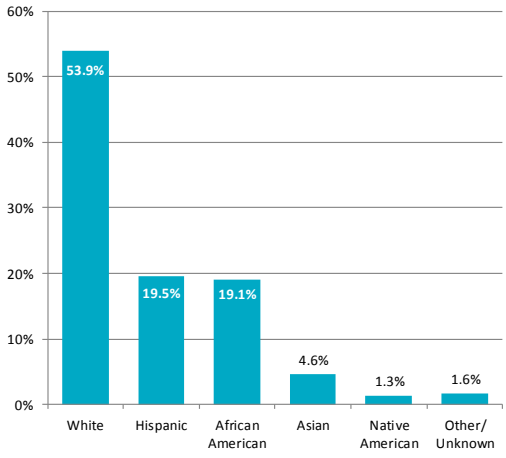
Clients receive services in their homes, at their workplace, or in other settings in the community they identify as the most beneficial to them or where support is most needed. Crisis intervention services are available 24 hours a day, 7 days a week.

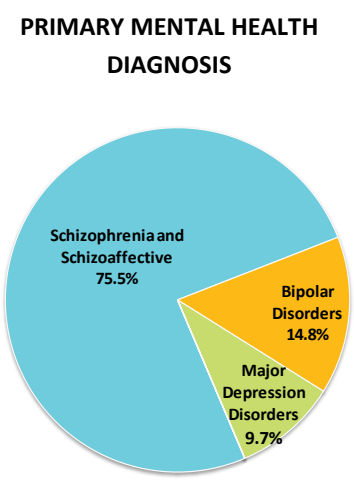
Drawing from a variety of sources, this report presents a system-level overview on service use and recovery-oriented treatment outcomes for individuals who received FSP services during Fiscal Year (FY) 2015-16. Demographic data and information on the use of inpatient and emergency psychiatric services come from the San Diego County CCBH (formerly Anasazi) data system. Data on basic needs (Housing, Employment, Education, Access to Primary Care Physician) and placements in restrictive and acute medical settings (Jail/Prison, State Hospital, Long-Term Care, and Medical Hospital) are drawn from the Department of Health Care Services (DHCS) Data Collection and Reporting (DCR) System used by all FSPs. Recovery outcomes and progress toward recovery data presented are from San Diego County's Mental Health Outcomes Management System (mHOMS).

917 Clients Served in FY 2015-16 — Demographics and Diagnoses







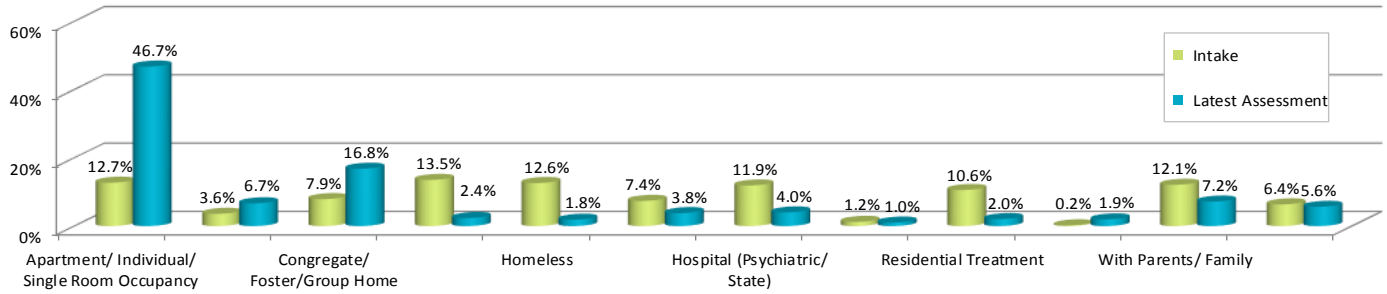


The following programs' data are included in this report (program name and Subunit #): Community Research Foundation (CRF) Impact (3401), North Star (3361), Center Star (3411), Pathways Catalyst (3391), and CRF Senior Impact (3481).

MEETING FSP ACT CLIENTS' BASIC NEEDS

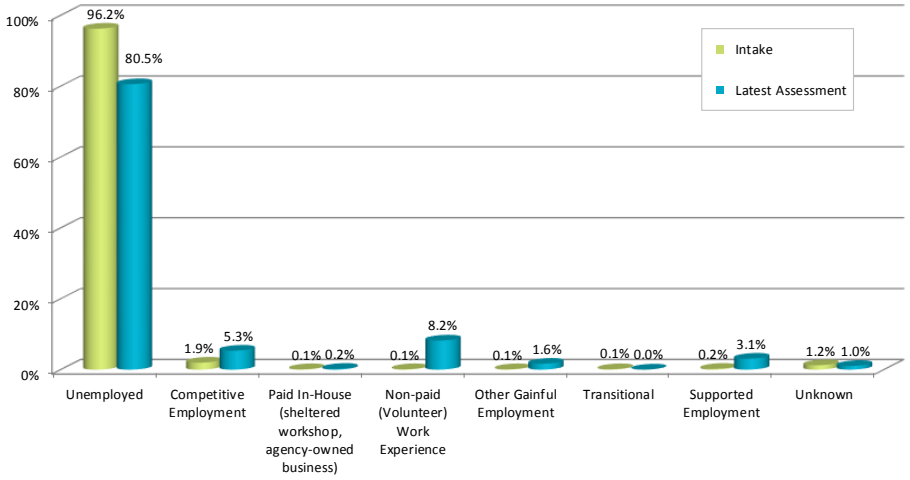
In FY 2015-16, FSP clients showed progress in several areas of basic needs. Significant improvements were seen in reduction of homelessness (12.6% at intake vs. 1.8% latest assessment) and housing in Emergency Shelters (13.5% at intake vs. 2.4% latest assessment). There were notable increases for housing in Apartment/Individual/Single Room Occupancy (46.7%) settings, Congregate/Foster/Group Homes (16.8%), and Assisted Living/Community settings (6.7%). Housing is often a primary goal for many FSP clients.

HOUSING



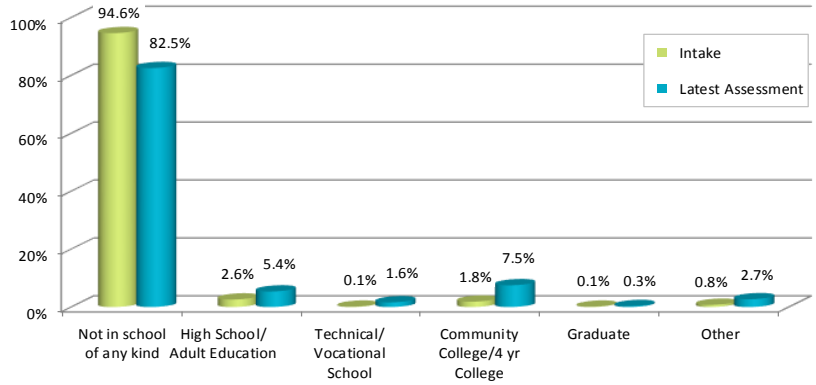
For some clients, involvement in meaningful occupational activities is an important part of recovery. FSPs can help connect clients to a variety of employment opportunities ranging from volunteer work experience to supported employment in sheltered workshops, to competitive, paid work. While most clients remained unemployed (80.5%), there was an improvement from intake to latest assessment with some clients moving from unemployed to other occupational statuses. The biggest gains were seen in movement into non-paid (volunteer) work experience (from 0.1% to 8.2%) and competitive employment (from 1.9% to 5.3%).

EMPLOYMENT



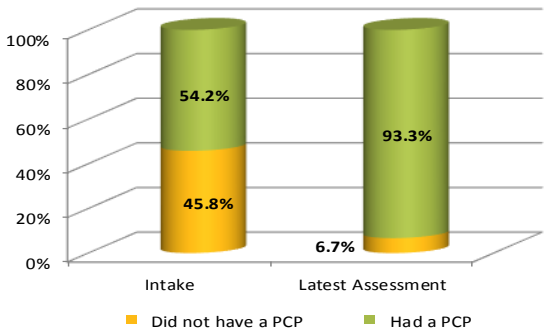
Education is a goal for some, but not all, people who received services. At intake, 5.4% of clients were enrolled in educational settings vs. 17.5% at the latest assessment.

EDUCATION



At the time of FSP enrollment, 54.2% of people reported having access to a primary care physician (PCP), while 93.3% of clients reported having a PCP at the time of their latest assessment.

CLIENTS WITH A PRIMARY CARE PHYSICIAN



Data source for all charts on this page: DHCS DCR 12/15/2016 download; Active clients in any period of FY 2015-16, N=976; Education data missing for 50 clients at intake and 43 clients at time of latest assessment. Clients may have more than one Employment or Education setting, so percentages in these categories may not necessarily total 100%.

CHANGES IN SERVICE USE AND SETTING

The "whatever it takes" model of care provided by full fidelity FSP ACT programs aims to help people avoid the need for emergency care, such as Emergency Psychiatric Unit (EPU), Psychiatric Emergency Response Team (PERT), Crisis Residential and Psychiatric Hospital. Overall, the number of these services used in FY 2015-16 decreased by 73.4%. Similarly, the number of individuals using these types of services decreased by 56.5% in FY 2015-16. The mean number of emergency services used per person decreased across EPU (100.0%), PERT (5.0%), Crisis Residential (23.9%), and Psychiatric Hospital (2.7%) categories. The overall number of services used per person decreased 38.7%.

USE OF INPATIENT & EMERGENCY SERVICES (PRE/POST)

	# OF SERVICES			# OF CLIENTS			MEAN # OF SERVICES PER CLIENT		
TYPE OF EMERGENCY SERVICE	PRE	POST	% CHANGE	PRE	POST	% CHANGE	PRE	POST	% CHANGE**
EPU	710	0	-100.00%	303	0	-100.00%	2.34	0.00	-100.00%
PERT	276	158	-42.75%	172	104	-39.53%	1.60	1.52	-5.00%
Crisis Residential	410	57	-86.10%	218	40	-81.65%	1.88	1.43	-23.94%
Psychiatric Hospital	774	363	-53.10%	299	144	-51.84%	2.59	2.52	-2.70%
Overall	**2,170**	**578**	**-73.36%**	**474***	**206***	**-56.54%**	**4.58**	**2.81**	**-38.65%**

*The overall numbers of clients PRE (n=474) and POST (n=206) indicate unique clients, many of whom used multiple, various services, while some clients used no emergency services.

**% change is calculated using the pre and post means.

PRE period data encompass the 12 months prior to each client's FSP enrollment and are from CCBH 10/2015 and InSyst 10/2009 downloads; FY 2015-16 California Department of Mental Health Data Collection and Reporting System (DCR) data from 12/15/2016 download used to identify active clients and for POST period data.

Clients in this analysis (n=760) had an enrollment date <= 7/1/2015 and Discontinued date (if inactive) > 7/1/2015. Data may include people who were discharged from FSP during the Fiscal Year but who continued to receive services.

In FY 2015-16, there was an overall decrease in the mean number of days per individual spent in restrictive settings: jail/prison, state hospital, and long-term care. The data on placement in acute medical settings are considered separately in the table below. 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 other illnesses requiring hospice or hospital-based medical care.

- Overall, both the number of days spent in restrictive settings and the number of people in placement decreased (by 59.9% and 55.1%, respectively).
- The largest decrease in the number of people in placement was for State hospital, with an 73.7% decrease.
- Both the number of days and number of individuals in acute medical settings increased (by 50.9% and 49.3%, respectively), suggesting that clients' access to medical treatment increased after FSP enrollment.
- Overall, the mean number of days per individual in restrictive settings decreased by 10.9% while the overall mean number of days per person in medical settings increased 1.1%.

PLACEMENTS IN RESTRICTIVE & ACUTE MEDICAL SETTINGS (PRE/POST)

	# OF DAYS			# OF CLIENTS			MEAN # OF DAYS PER CLIENT		
TYPE OF SETTING	PRE	POST	% CHANGE	PRE	POST	% CHANGE	PRE	POST	% CHANGE**
Jail/Prison	15,992	6,385	-60.07%	145	66	-54.48%	110.29	96.74	-12.28%
State Hospital	1,897	189	-90.04%	19	5	-73.68%	99.84	37.80	-62.14%
Long-Term Care	5,361	2,739	-48.91%	23	14	-39.13%	233.09	195.64	-16.06%
Overall	**23,250**	**9,313**	**-59.94%**	**178***	**80***	**-55.06%**	**130.62**	**116.41**	**-10.88%**
Medical Hospital	1,202	1,814	50.92%	73	109	49.32%	16.47	16.64	1.07%

*The overall numbers of clients PRE (n=178) and POST (n=80) indicate unique clients, many of whom used multiple, various services, while some clients used no services.

**% change is calculated using the pre and post means.

Data source: DHCS DCR 12/15/2016 download; 12 month pre-enrollment DCR data rely on client self-report.

Clients in this analysis (n=695): had an Enrollment date <= 7/1/2015 and Discontinued date (if inactive) > 7/1/2015; Clients had to be active throughout the FY to be included.

MEASURING PROGRESS TOWARDS RECOVERY

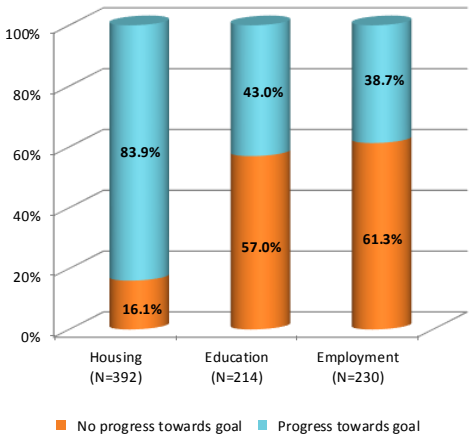
Comparing NEW and ALL FSP ACT Program Clients Means for Assessments 1 and 2

FSP ACT program clients' progress toward recovery is measured using two different instruments—the Illness Management and Recovery Scale (IMR) and the Recovery Markers Questionnaire (RMQ). Clinicians use the IMR scale to rate their clients' progress towards recovery. The IMR has 15 individually scored items; scores can also be represented using subscales or overall scores. Individuals receiving services use the 24-item RMQ scale to rate their own progress towards recovery. Higher ratings on both the IMR and the RMQ indicate greater recovery. Mean IMR and RMQ assessment scores range from 1-5.

The IMR and RMQ scores displayed in the charts below compare scores of "NEW" clients to those of "ALL" clients. NEW clients are those who started receiving services in 2015 or later, who had two IMR/RMQ assessments during FY 2015-16 (Assessments 1 and 2), and whose first service date was within 30 days of their first IMR assessment. ALL clients includes every individual who had two IMR/RMQ assessments during FY 2015-16 (Assessments 1 and 2), regardless of how long they have received FSP services. Scores for NEW clients more directly demonstrate the effect of FSP services on client outcomes because ALL clients includes those people who may have been receiving services for long periods of time, starting before the implementation of FSP programs.

NEW clients' IMR scores at intake were lower than ALL clients' scores but NEW clients achieved greater gains between intake and latest assessment while ALL clients' scores remained stable. Both NEW and ALL clients' RMQ scores were higher than their IMR scores, indicating that both NEW and ALL clients tend to rate their progress higher than clinicians do. RMQ scores for both NEW clients and ALL clients increased, but a greater increase was observed for NEW clients.

MAKING PROGRESS TOWARDS KEY TREATMENT GOALS



Clients Whose Treatment Plan Includes Key Progress Goals — Progress at Latest IMR Assessment

In their IMR assessments, clinicians also note client progress toward goals related to housing, education, and employment. The chart on the left illustrates progress made by those individuals whose treatment plan included one or more of these key goals. It should be noted that both education and employment are longer-term goals than housing.

Of those people with a housing goal on their treatment plan, 83.9% demonstrated progress toward the goal, while 16.1% did not. Of those with an education goal on their treatment plan, 43.0% demonstrated progress, while 57.0% did not demonstrate progress. And of those people with an employment goal on their treatment plan, 38.7% demonstrated progress toward the goal, while 61.3% did not.

Data source for all charts on this page: HOMS FY 2015-16; Data include all HOMS entries as of 12/15/2016 for clients who received services in FSP ACT Model Programs, finished IMR/RMQ assessment 2 during FY 2015-16, and who had paired IMR/RMQ assessments within 4-8months.

KEY FINDINGS AND DISCUSSION

The FSP ACT teams with MHSA housing funds have continued to make progress with the clients served in their programs. The population that the FSP ACT model primarily aims to serve are homeless persons with serious mental illness (SMI). As of 2017, 39% of the homeless population in San Diego County identified as having mental health issues (an increase from 14% in 2016).[1] Males make up 69% (n=1,087) of the overall homeless population. By comparison, the homeless population receiving FSP services is 58.1% male (n=917), suggesting that there may be a service gap for males.

There were some notable changes in the population in the report as compared to FY 2014-15. The rate of females served decreased (41.9% compared to 43.9%). The percent of clients in FSP programs in the <18-25 and 25-59 age categories changed slightly (24.3% to 22.0% and 55.7% to 56.4%, respectively), while the proportion of clients age 60 and older served increased, from 20.0% to 21.6%. This indicates a shift toward FSP programs serving older adult clients more frequently than young adult, transition aged youth (TAY), and adult populations. Further analysis of client age would allow for greater understanding of this population shift. Clients served with a primary diagnosis of Schizophrenia/Schizoaffective disorders increased from last year (75.5% compared to 70.9%) and a decrease was observed in the proportion of clients served with Bipolar Disorders (14.8% compared to 17.8%). This trend is consistent with the shift in primary mental health diagnosis proportions between FY 2013-14 to FY 2014-15, as well. Diagnoses other than Schizophrenia/ Schizoaffective, Bipolar Disorder, and Major Depression Disorders were not observed in FY 2015-16.

The basic needs assessed are housing, employment, and education. Housing trends remained the same from last fiscal year, and a homelessness rate of 1.8% for clients was achieved at latest assessment. Nearly all clients were unemployed at intake, and this rate decreased with the involvement of the ACT teams. This was even more pronounced than the reduction seen from intake to latest assessment in FY 2014-15. Improvement was seen in the rate of those in an education setting from intake to latest assessment in a consistent trend to FY 2014-15. Nearly all clients reported having access to a PCP at the latest assessment, though this percentage was lower than FY 2014-15 (93.3% compared to 96.5%).

Outpatient care is associated with reductions in cost of inpatient and emergency services. Inpatient and emergency service use decreased from intake to the latest assessment, and the percent reduction in mean number of services per client was much greater than last year (38.7% vs 21.0%). Overall, placements in restrictive and acute medical settings decreased from intake to latest assessment, though not as much as the previous year. The number of clients requiring these services at latest assessment remained similar; however, the number of days utilized in FY 2015-16 increased substantially. Therefore, the rate of reduction in mean days per client was not as large as FY 2014-15. The number of days of acute medical hospital use at latest assessment remained close to the same number of days as FY 2014-15; however, the number of clients using an acute medical hospital has increased since last year, which results in a much less pronounced mean number of days per client using these services (+1.1% compared to +34.1%).

As previously discussed in this report, the changes for NEW clients recovery progress more clearly demonstrates the effect of FSP services since ALL clients may have begun receiving services before FSP programs were established. Given this, observed differences between IMR and RMQ mean scores from first assessment to latest assessment were negligible for ALL clients. However, improvements were visible for NEW clients for IMR means from intake to latest assessment. The latest IMR mean score was quite similar to last year (3.01 compared to 3.03), while the RMQ score for NEW clients remained very close (3.48 compared to 3.47). NEW clients' self-rated progress towards outcomes on the RMQ increased from assessment 1 to assessment 2 (2.96 to 3.48), though this change was not statistically significant.

Clients with progress on housing goals and education slightly increased from last year to this year (83.9% vs 82.8% and 43.0% vs 42.6%, respectively), while employment progress toward goals decreased this year compared to last (38.7% vs 42.9%). Housing is a top priority of FSP ACT programs, so maintaining this progress is important.

Overall, most of the outcomes evaluated have shown slightly less improvement when compared to last fiscal year, though changes made from intake to latest assessment are still indicating improvement. Shifts in demographic characteristics of the population should be monitored to ensure that services and outreach are tailored to meet the needs of an aging population.

1 http://www.rtfhsd.org/wp/wp-content/uploads/2011/08/A-general-fact-sheet-final.pdf

Appendix F

Community Services and Supports (CSS)

FY 2015-16 Annual Report

FY 2015-16 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

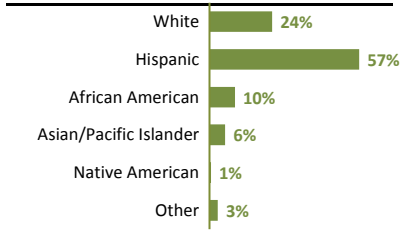
LIVE WELL SAN DIEGO

CY-FSP (n=3,238)

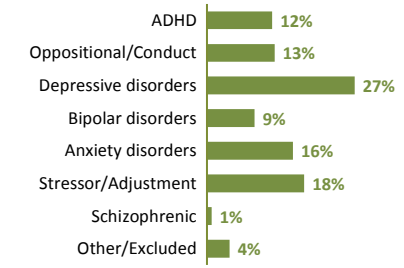
Living Situation	%
House or Apartment	88%
Correctional Facility	3%
Foster Home	2%
Group Home	2%
Residential Trmt Ctr	1%
Children's Shelter	<1%
Homeless	3%
Other/Unknown	2%

Language	%
English	81%
Spanish	17%
Arabic	<1%
Vietnamese	1%
Tagalog	<1%
Other/Unknown	1%

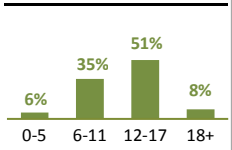
Race/Ethnicity



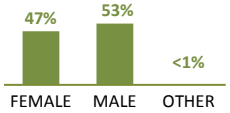
Diagnosis



Age

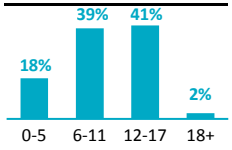


Gender

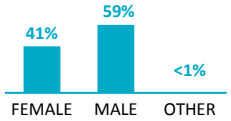


CY-OE (n=981)

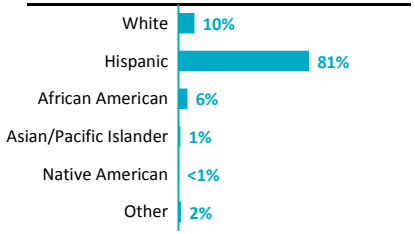
Age



Gender



Race/Ethnicity



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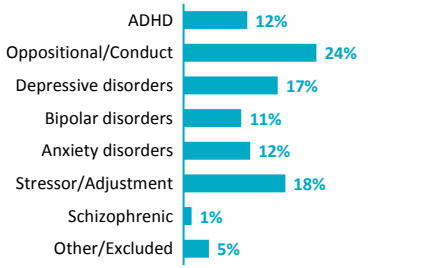


Living Situation	%
House or Apartment	95%
Correctional Facility	1%
Foster Home	<1%
Group Home	<1%
Residential Trmt Ctr	<1%
Children's Shelter	<1%
Homeless	3%
Other/Unknown	<1%

Language	%
English	67%
Spanish	32%
Arabic	<1%
Vietnamese	<1%
Tagalog	0%
Other/Unknown	<1%

CY-FSP **13%** (3,238)

CY-OE **4%** (981)

Total CSS Clients *(unduplicated)* N = 25,138

CY-SD **8%** (2,010)

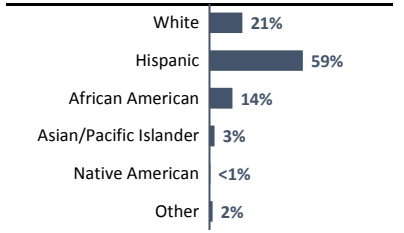
ALL-OE **1%** (235)

CY-SD (n=2,010)

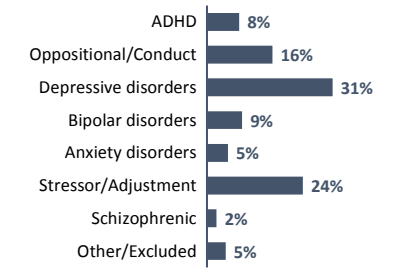
Living Situation	%
House or Apartment	56%
Correctional Facility	22%
Foster Home	13%
Group Home	3%
Residential Trmt Ctr	2%
Children's Shelter	1%
Homeless	1%
Other/Unknown	1%

Language	%
English	89%
Spanish	10%
Arabic	<1%
Vietnamese	0%
Tagalog	<1%
Other/Unknown	1%

Race/Ethnicity



Diagnosis



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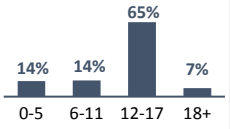
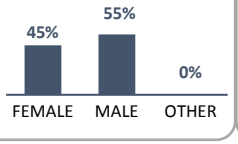
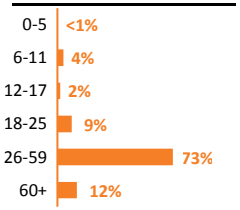


Gender

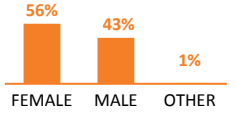


ALL-OE* (n=235)

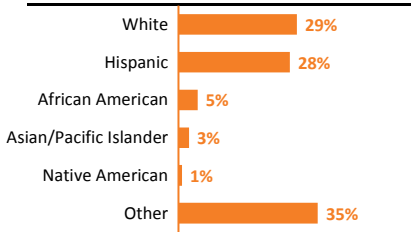
Age



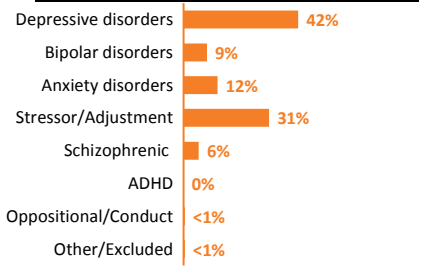
Gender



Race/Ethnicity



Diagnosis



Living Situation	%
Lives Independently	90%
Justice Related	0%
Board & Care	1%
Insitutional	0%
Foster Home	0%
Group Home	0%
Residential Trmt Ctr	0%
Children's Shelter	0%
Homeless	6%
Other/Unknown	3%

Language	%
English	27%
Spanish	12%
Arabic	18%
Vietnamese	0%
Tagalog	0%
Other/Unknown	43%

**Clients may be duplicated*

FY 2015-16 Community Services and Supports (CSS)

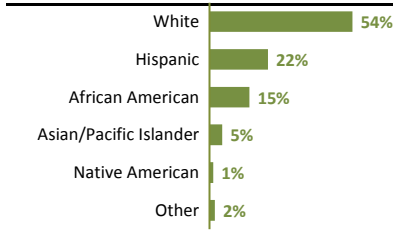
County of San Diego Behavioral Health Services — MHSA CSS Programs

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

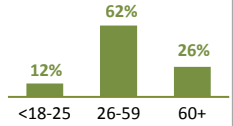
TAOA-FSP (n=3,931)

Living Situation	%
Lives Independently	53%
Board & Care	16%
Justice Related	1%
Homeless	11%
Institutional	14%
Other/Unknown	5%

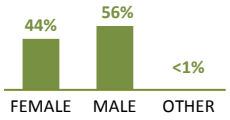
Race/Ethnicity



Age

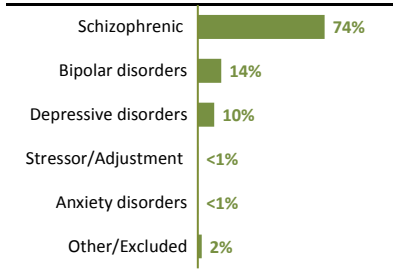


Gender



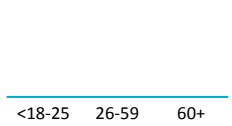
Language	%
English	92%
Spanish	4%
Arabic	<1%
Vietnamese	<1%
Tagalog	<1%
Other/Unknown	3%

Diagnosis



TAOA-OE (n=0)*

Age

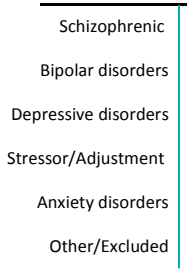


Gender

Race/Ethnicity

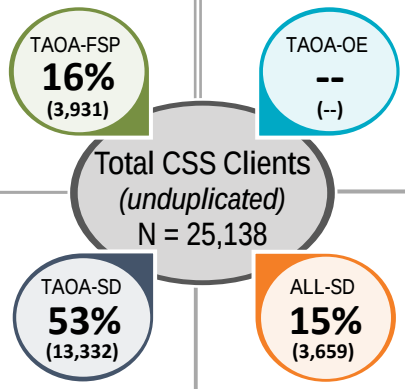
Living Situation	%
Lives Independently	
Board & Care	
Justice Related	
Homeless	
Institutional	
Other/Unknown	

Diagnosis



Language	%
English	
Spanish	
Arabic	
Vietnamese	
Tagalog	
Other/Unknown	

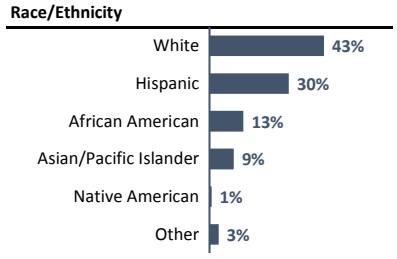
*TAOA-OE programs were not active in FY 2015-16



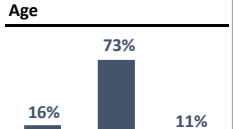
TAOA-SD (n=13,332)

Living Situation	%
Lives Independently	67%
Board & Care	7%
Justice Related	1%
Homeless	13%
Institutional	1%
Other/Unknown	12%

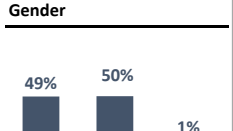
Race/Ethnicity



Age

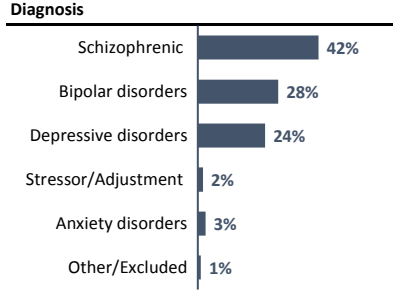


Gender



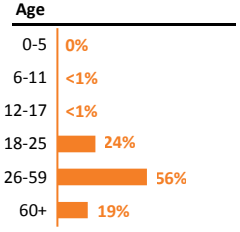
Language	%
English	78%
Spanish	7%
Arabic	1%
Vietnamese	2%
Tagalog	<1%
Other/Unknown	12%

Diagnosis

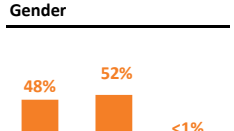


ALL-SD† (n=3,659)

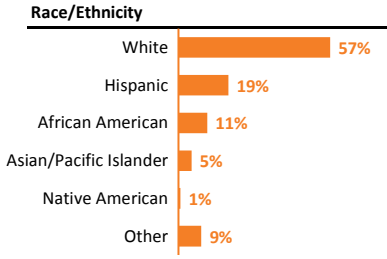
Age



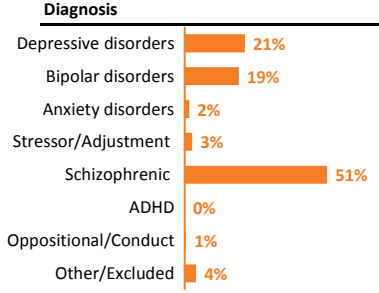
Gender



Race/Ethnicity



Diagnosis



Living Situation	%
Lives Independently	72%
Justice Related	1%
Board & Care	5%
Insitutional	2%
Foster Home	0%
Group Home	0%
Residential Trmt Ctr	0%
Children's Shelter	0%
Homeless	17%
Other/Unknown	3%

Language	%
English	89%
Spanish	2%
Arabic	6%
Vietnamese	<1%
Tagalog	<1%
Other/Unknown	2%

†Clients may be duplicated

Appendix G

Prevention and Early Intervention System Wide Summary

CHILD & ADULT PEI PROGRAMS

SYSTEMWIDE SUMMARY

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES
PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2015—2016 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. San Diego County has funded 25 contractors to provide PEI programs for adults and older adults, and eight contractors for 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. This information is summarized in the following report.

DATA: Child and Adult PEI Programs

REPORT PERIOD: 7/1/2015-6/30/2016

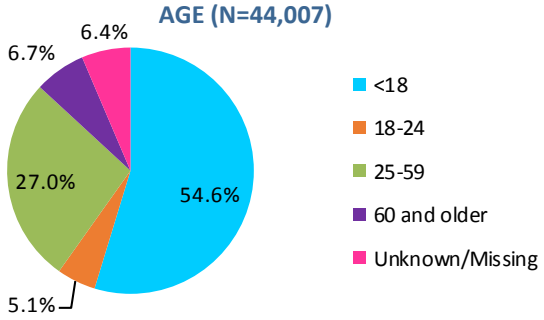
NUMBER OF PARTICIPANTS WITH DATA IN FY 2015-16: 44,007 (Unduplicated)*†

**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.*

†All known duplicates are excluded from this count; however, unduplicated status cannot be verified among programs that do not issue client identification numbers.

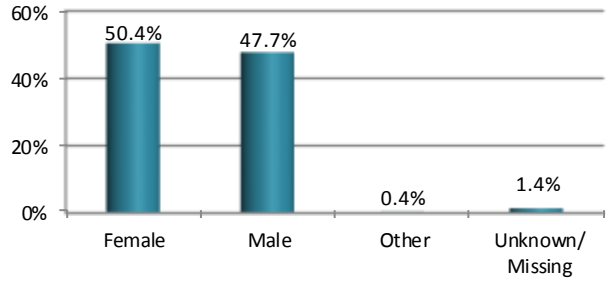
SYSTEMWIDE PARTICIPANT DEMOGRAPHICS

AGE (N=44,007)



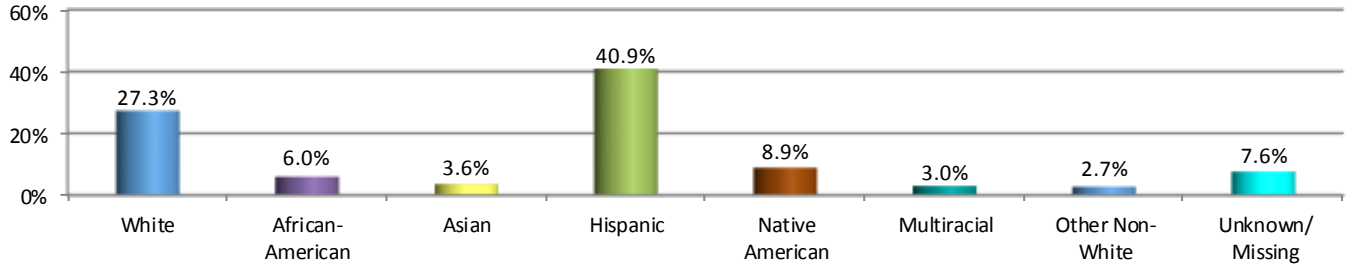
Fifty-five percent of participants were under the age of 18 and 27% were between the ages of 25-59.

GENDER (N=44,007)



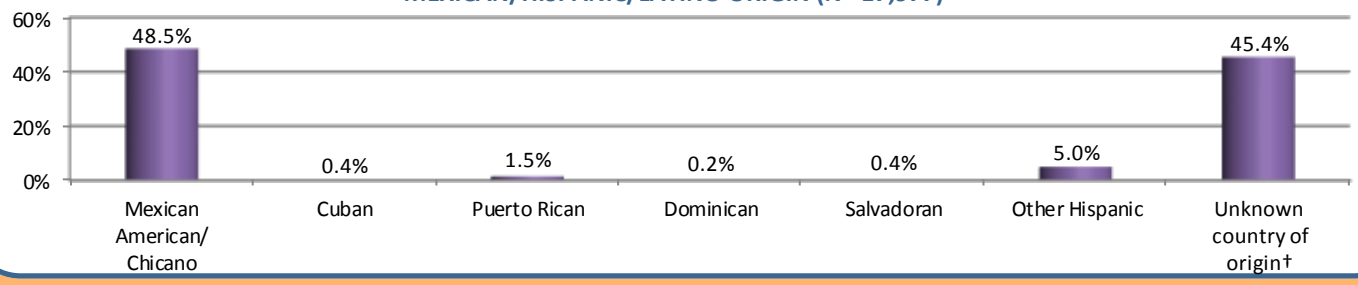
Fifty percent of participants who received services identified their gender as female.

RACE/ETHNICITY (N=44,007)*



Forty-one percent of participants who received services identified their ethnic background as Hispanic. Race/ethnicity was not reported for 8% of the participants.

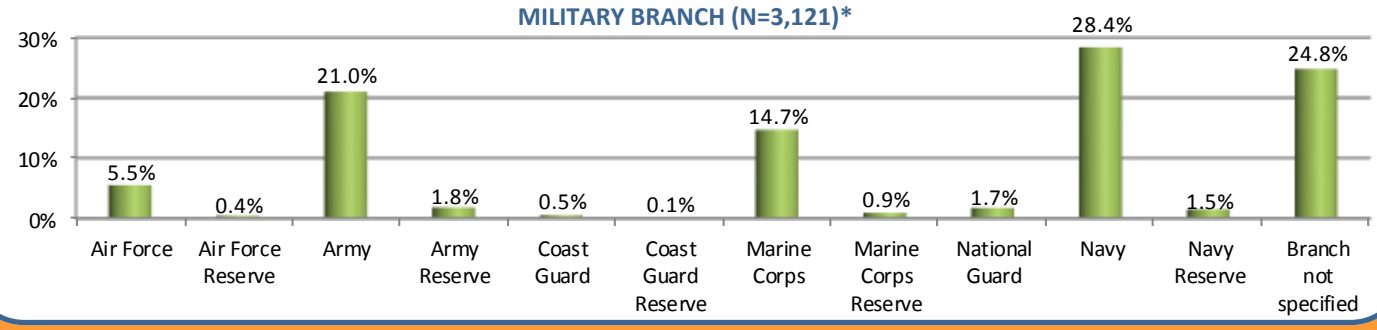
**Participants can self-identify as more than one race/ethnicity so percentages may add up to more than 100%.*



Of the Hispanic population served, 49% identified their ethnic background as Mexican American/Chicano.

**Participants can self-identify as more than one ethnicity so percentages may add up to more than 100%.*
†Some PEI programs did not ask Hispanic participants to list their country of origin. Participants from these programs are included in the unknown category.

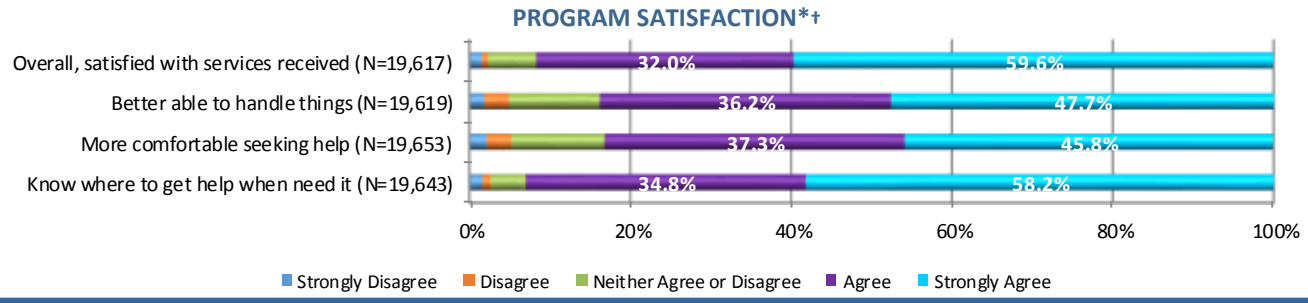
MILITARY SERVICE



In the adult PEI programs, participants were asked about their own military involvement. The children's PEI programs reported whether the children's caregivers had served in the military. Of the 14,420 participants in both systems for whom military service status was known, 3,121 (22%) stated that either they or their child's caregiver had served in the military. The majority of these individuals served in the Navy (28%), the Army (21%) or the Marine Corps (15%). The remaining military branches were not highly represented.

**Participants could have served in more than one military branch so percentages may add up to more than 100%.*

PROGRAM SATISFACTION



Information on satisfaction with the PEI programs was available for approximately 45% of the participants. Of these participants, most agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 92% of the participants who responded were satisfied with the services they received.

**Satisfaction data not available for all participants.*
†Satisfaction data includes duplicate participants.

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.

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.

Appendix H

2016 Community Engagement Report

COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
COMMUNITY ENGAGEMENT REPORT 2016

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO | HOFFMAN CLARK+ associates

2016 COMMUNITY ENGAGEMENT REPORT

County of San Diego Health & Human Services Agency
Behavioral Health Services

Agency:	County of San Diego Health & Human Services Agency Behavioral Health Services 3255 Camino del Rio South San Diego, CA 92103
Project Contact:	Adrienne Yancey, MPH MHSA Coordinator Behavioral Health Services County of San Diego Health & Human Services Agency 619-584-5075 Adrienne.Yancey@sdcounty.ca.gov
Report Authors:	Joann Hoffman, MPH, PhD Carl McKinney, PhD Hoffman Clark + Associates 731 S. Hwy. 101, #19 Solana Beach, CA 92075 858-350-9507 joann@hoffmanclark.org carl@hoffmanclark.org Valerie Nash, MA Nash & Associates 2801 B Street #157 San Diego, CA 92102 619-822-2444 valerie@nashandassociates.com

Table of Contents

I. OVERVIEW: 2016 COMMUNITY ENGAGEMENT

Behavioral Health Services (BHS) of the County of San Diego Health & Human Services Agency (HHSA) is engaged in an ongoing Community Planning Process (CPP) that helps to inform decision-making, including how to best use Mental Health Services Act (MHSA) funding to achieve positive health outcomes. This process includes the participation of the San Diego County Behavioral Health Advisory Board and the System of Care Councils, as well as other community organizations, stakeholders, and individuals.

In 2016, Hoffman Clark + Associates (HCA) was contracted to design and conduct regional community forums and focus groups throughout the County of San Diego. The goal was to continue to gather input from community stakeholders including consumers and family members regarding services within the BHS System of Care. This report presents and analyzes community input data. It is anticipated that the results will be incorporated into the County's 10-year Roadmap, which is a strategic vision framework aligned with the mission, vision and values of the County of San Diego including Live *Well San Diego* and intended to guide BHS planning.

What are the deeper learnings from the community engagement process?

Meaningful engagement is valued and desired. An across-the-board message from participants in the 2016 community engagement process was that they valued the opportunity to have their voices heard. More than 650 stakeholders, including providers, consumers, and other individuals, came to the table to envision a bright future for Behavioral Health Services and to give their input on how to effect meaningful change. Many suggested deeper and sustained participation in the Community Planning Process as part of their vision, and made specific requests and suggestions for additional engagement activities.

Care coordination and a seamless continuum of care are both viewed as critical. When the community engagement data was decoded and analyzed, the topics of care coordination and continuum of care emerged as essential priorities. Greater connectivity within the provider community and with BHS, education and information sharing, and integration of services across systems were key components of an overall vision.

Access to services and education and awareness were the most pressing concerns in the area of children's behavioral health. The community expressed a need for home-based services and services embedded in schools, and for education programs and campaigns targeting parents, teachers, school staff, and students, with the goals of enhancing awareness of behavioral health issues, normalizing and destigmatizing these issues, and teaching skills for dealing with them.

Unserved and underserved populations warrant focused attention. The community engagement process surfaced many actionable solutions to how to best meet the needs of specific target populations. Some of these populations were the focus of the smaller groups or community conversations, while others such as refugees or individuals who are deaf or hard of hearing were discussed during community forums. Understandably, an increase in services was the top request. Across all regions, the need for culturally competent services was noted, along with suggestions for consumer-driven and peer-led services. Other requests were for stigma reduction, public education, and the establishment of mobile and one-stop centers of care.

Barriers relating to housing and transportation are of paramount concern. It is clear that issues of housing and transportation are closely connected to behavioral health, and that they cut across the areas of Care Coordination, Unserved and Underserved Populations, and Children's Behavioral Health. Participants offered solutions in these areas that range from simple suggestions to provide BHS consumers with greater access to bus passes, to innovative ideas to address problems of homelessness.

How do the results of the community engagement process inform BHS's 10-year Road Map? The stories that emerged from the community engagement process in 2016 show that the county's 10-year Roadmap is on track. However, feedback across regions and topics suggested that consumer and provider awareness of BHS programs, and ongoing co-leveraging collaboration across services is seen as a critical. These processes, although included in all areas of the Roadmap, may need to be elevated into a stand-alone service area to be more visible, intentional, and measurable. This is especially imperative for the disenfranchised and those communities often lacking a voice

Many of the solutions proposed do not require more funding or a dramatic change in policy or practice on the part of BHS. They are more a call to action: a call for authentic and ongoing community engagement in order to inform, communicate, and collaborate around a shared vision that entails both low and high tech innovative solutions to help the most vulnerable community members navigate through the behavioral health system.

How did we arrive at these results? The 2016 community engagement process is summarized below, with more detail of the methodology following in section II.

Who? More than 650 stakeholders, including providers, consumers, and other individuals, participated in the 2016 community engagement process: 553 stakeholders at twelve regional forums, and more than 100 representatives from target populations (Native American, Southeastern San Diego Community, Justice Partners, Male and Female incarcerated individuals, and Peer Workers) who attended six special focus groups. Demographics of forum attendees were collected.[1]

What? In conversation with the BHS team, HCA identified the World Café as a model for the community forums that would allow us to channel input into three identified priority areas: Children's Behavioral Health, Care Coordination, and Unserved/Underserved Populations. Our adaptation of this method, the Conversation Café, was scalable to community turnout and encouraged collaborative envisioning of future possibilities in the three priority areas and next steps for realizing those possibilities. They also allowed for community input on the desirability of four proposed Innovation Projects in line with MHSA requirements. The six special groups were selected based on feedback from the community planning process in previous years, and provided an opportunity to pay targeted attention to specific populations.

When? Late August through early November of 2016.

Where? Two forums, one in the day and one in the evening, were held in community centers or county facilities in each of the six HHSA regions. Special groups met at the San Diego County Hall of Justice, NAMI San Diego, the CARE Community Center, Las Colinas Detention and Reentry Facility, the George Bailey Detention Facility, and the Rincon offices of the Indian Health Council.

[1] Forum Feedback was reported previously; a copy of this report with demographics and participant feedback is included in Appendix A.

Why? Community engagement – gathering data from and providing feedback to the community – is a required component of MHSA funding, and is also part of both the Live Well vision and a guiding principle of BHS.

II. Process Methodology

Community Forums. In meetings with Behavioral Health Services, several ideas and issues emerged that informed the forum process:

- The history of the community engagement process, data collected, and community response to the process
- Desire to encourage community members to delve deeper into specific topic areas
- Focusing on the topics of Underserved/Unserved Populations, Children's Behavioral Health, Care Coordination, and Innovation
- Aim to have participants give input on all of the focus areas
- Preference for the HCA team members to facilitate forums to avoid the potential bias of having county staff facilitate the process
- Need for a short infographic to provide historical context and to summarize how past community planning informed program funding
- Need to collect demographic data from forum participants
- Need to vet proposed Innovation projects
- Application of the World Café model to the forum process to engage the community through the lens of Appreciative Inquiry

Appreciative Inquiry is based on a social constructivist approach that asks questions aimed at strengthening system capacity by focusing on productive potential.[2] The process begins with an unconditionally positive question. The initial question posed to forum participants was, "What do we need for a Brighter Future for Behavioral Health Services?" The participants made progressive rounds amongst tables to participate in collective conversations about the future in each of the three topic areas. In most of the forums each table was hosted by a HCA facilitator. Participants were also asked to discuss concrete 'Next Steps' for moving toward the positive future they had collectively envisioned. Participants were directed to come to a consensus on key ideas before moving to the next topic. Consensus ideas were harvested and graphically recorded. The participants also spent a 15-minute round discussing the four proposed Innovation Programs. Finally, participants were asked to fill out a questionnaire about the forum process, which included demographic questions.

Special Groups. The protocols for the special group meetings were developed with input from BHS and/or stakeholder organizations connected to the participants. In each case an emphasis was placed upon developing questions that would facilitate meaningful participation and result in the identification of actionable solutions. Consideration was given to the size of the group and background of the attendees. Partners in these efforts included: Public Safety Planning Group (Justice Partners); NAMI and RI International (Peer Workers); Indian Health Council (Native American community); and Live Well Communities Task Force (Southeastern San Diego community). Details of group processes are included in the full reports in Appendices E through J. A summary of these groups is provided in section IV.

[2] JM Watkins & BJ Mohr. *Appreciative Inquiry: Change at the Speed of Imagination*. New York: Wiley, 2011.

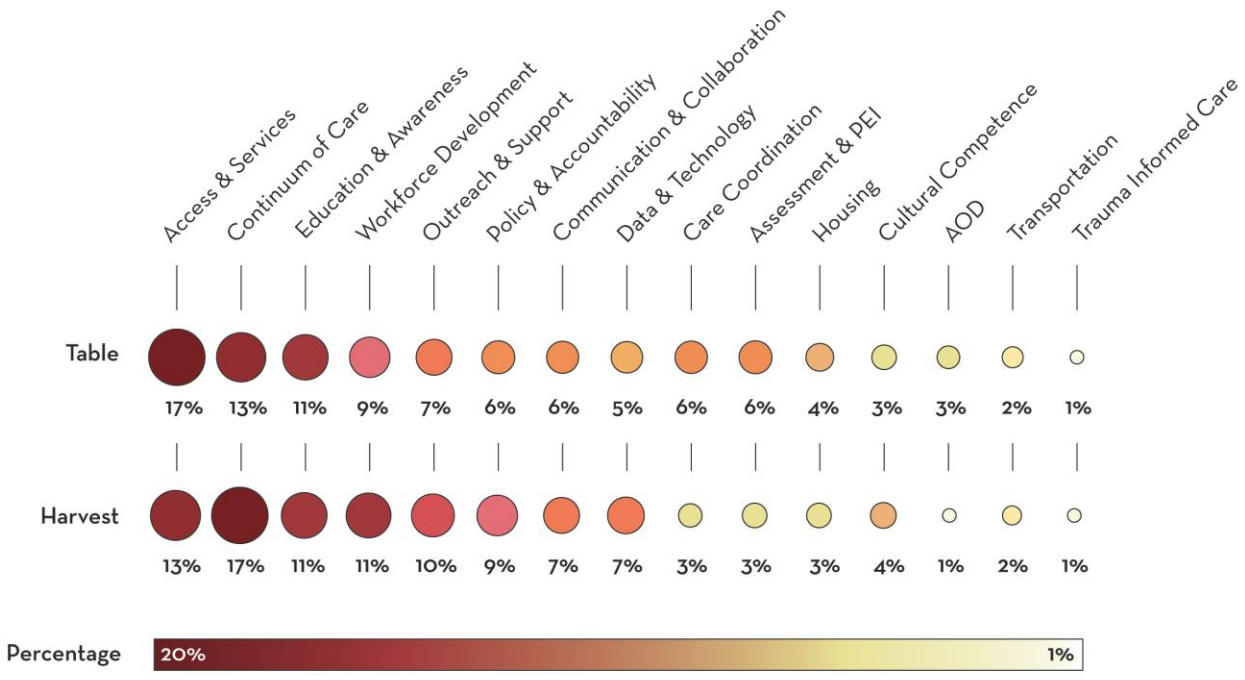
III. Community Forums

Data was collected at the Community Forums in four ways: 1) Participants and facilitators at each table noted ideas on tabletop papers; 2) Key ideas were 'harvested' from each table to capture central themes of each forum; 3) A 'parking lot' allowed participants to contribute ideas and concerns not covered in table conversations; and 4) A questionnaire was distributed at the end of each forum to gather demographics and feedback on the process. Questionnaire data can be found in Appendix A. Parking Lot data can be found in Appendix B, and is reported below in section F. Harvest and Table data are reported below in section A, and broken out by topic in sections B through E. Data was also graphically recorded and aggregated into a 3'x6' visual, and an interactive data story was published online and will be available to the public. See Appendix K.

A. Harvest & Table Data

Both Harvest and Table data were entered into NVivo and Kumu to analyze and visualize clustering of frequently recurring concepts. This yielded a set of 15 'Essential Themes' into which all data was coded.[3] Two members of the HCA team conducted coding, with 94% inter-rater reliability in a 10% sample. Coded Harvest and Table data were compared to validate the representativeness of the harvest. Across all six regions and three topic areas, there is significant proportional correlation (r = .876) between Harvest and Table data. See Figure 1.

Figure 1. Harvest & Table Data Across all Regions



However, when sliced by topic and region, disparities between Harvest and Table data are revealed even as correlation remains significant (r = .841 for topics; r = .733 for regions). Dominant categories such as Access & Services, Continuum of Care, Workforce Development, and Education & Awareness

[3] See Appendix C for an explanation of these categories.

continue to stand out, but notable differences in some areas emerge. For example, Outreach & Support registered at 23.2% in the Harvest from the Central Region but only 5.3% at the Tables. See Figures 2 and 3. This is likely due to the smaller sample size as the data is sliced thinner, but can also expose more granular distinctions at topical and regional levels between community concerns expressed at the tables and those captured in the harvest. For this reason, while the harvesting of data was useful for the overall graphic recording of community input across the county, we base our analysis primarily on data captured at the tables.

Figure 2. Harvest & Table Data by Topic

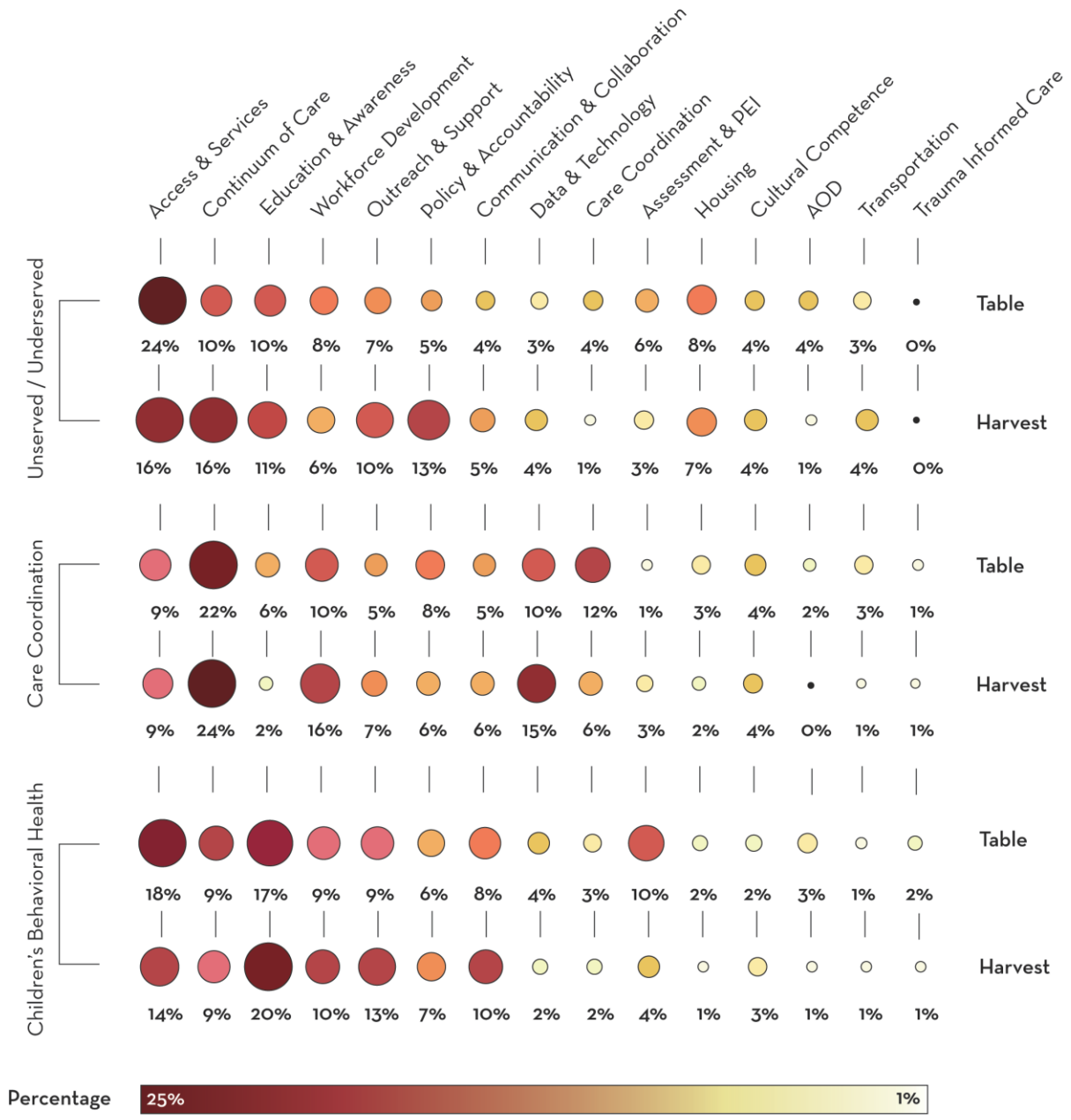


Figure 3. Harvest & Table Data by Region

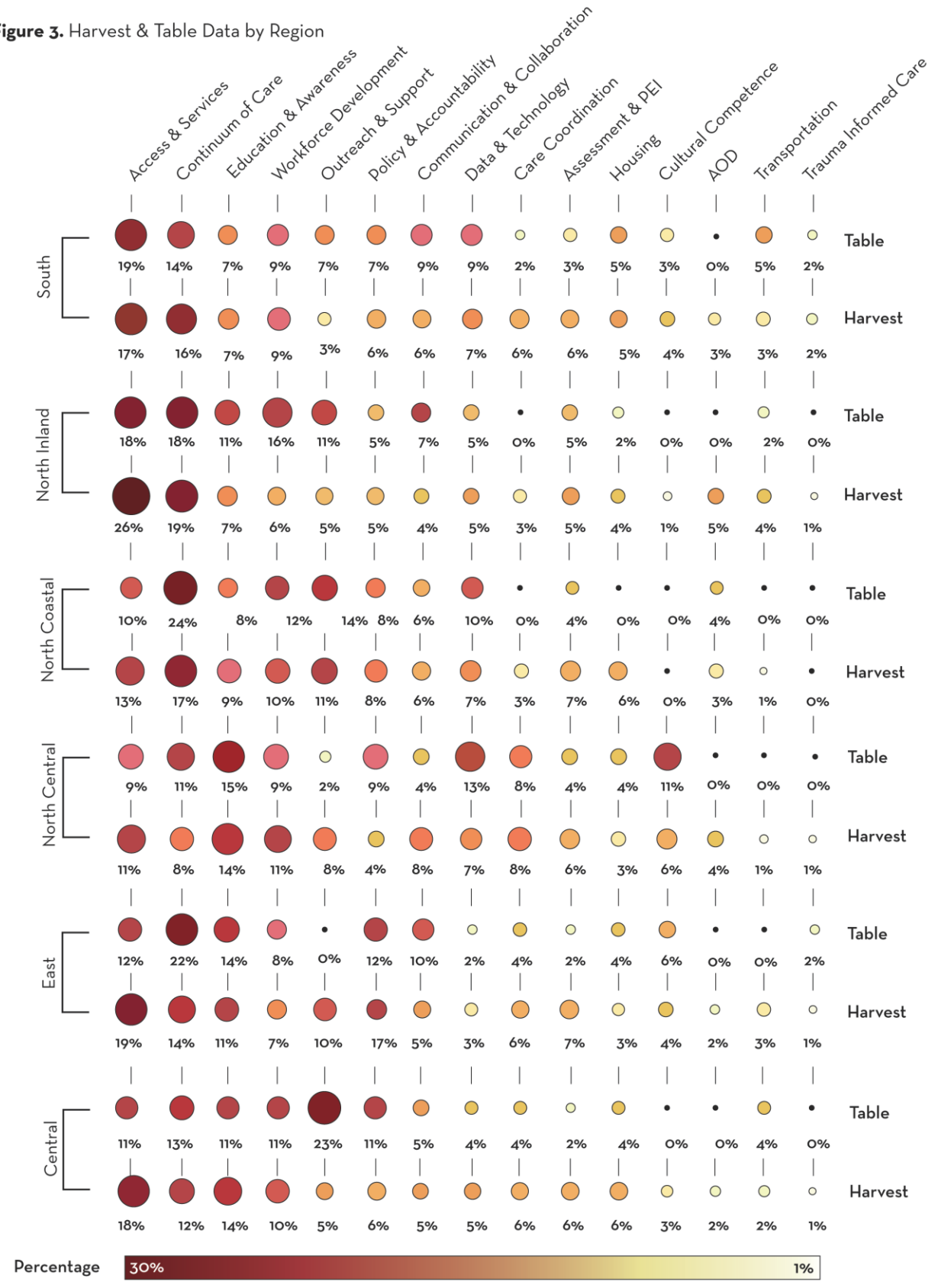
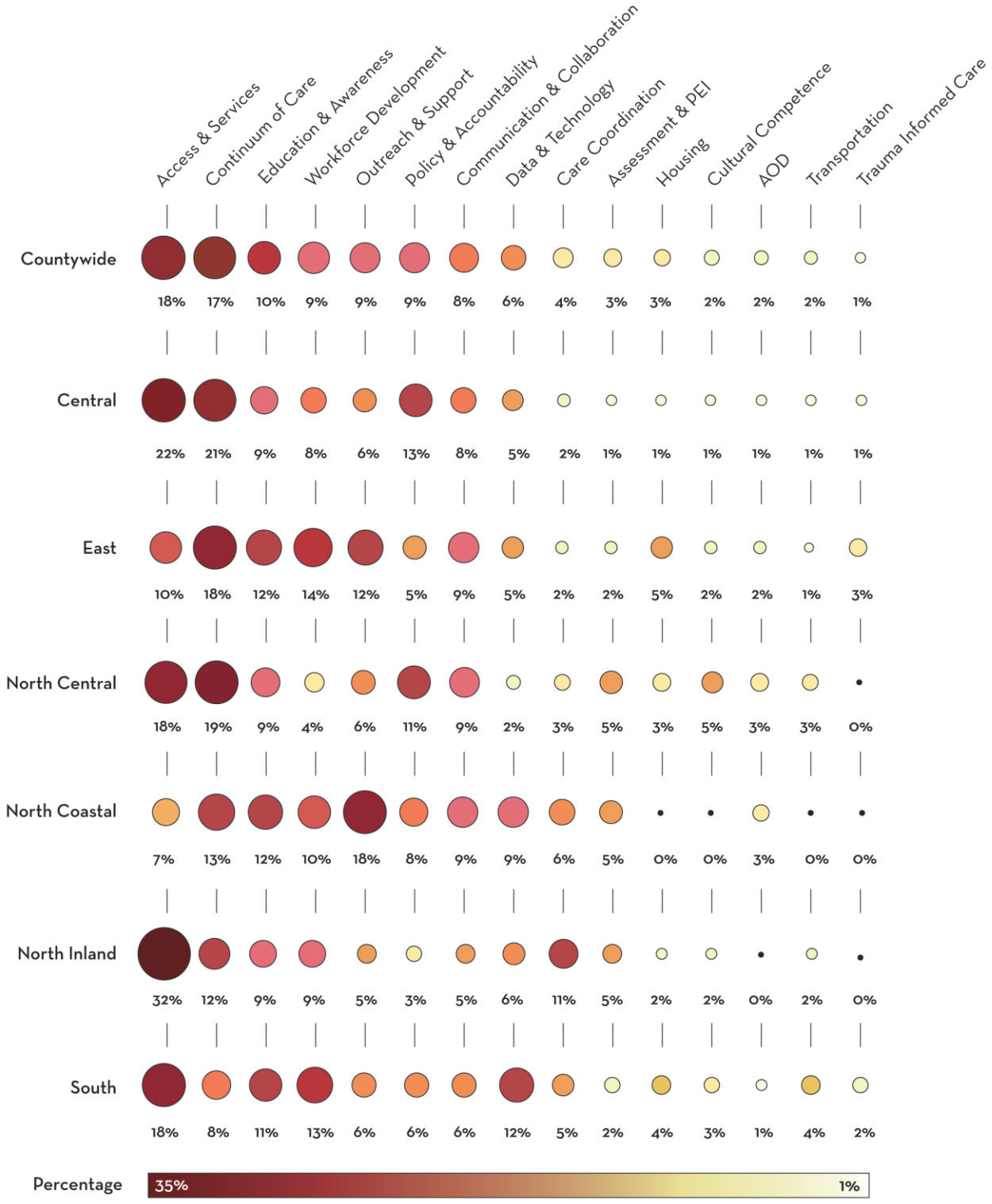


Table data is broken out by topic below, with regions visually indexed to a priority scaling of county 'Essential Themes' overall. Categorical weight as measured by percentage is shown in both size and tone, which reveals prominent priorities for each topic as well as some significant regional differences. See Appendix D for Table data broken out by region with topics indexed to the county overall.

B. Children's Behavioral Health

Figure 4 maps the 15 Essential Themes within the topic of Children's Behavioral Health across the six HHSA service regions of San Diego County and indexes them against the county overall, revealing regional differences in prioritization of concerns.

Figure 4. Children's Behavioral Health by Region



Access & Services and Education & Awareness are the predominant categories in this topic area at 17.8% and 16.6% of 851 comments countywide. In particular, the community expressed a need for home-based services and services embedded in schools, and for education programs and campaigns

targeting parents, teachers, school staff, and students, with the goals of enhancing awareness of behavioral health issues, normalizing and destigmatizing these issues, and teaching skills for dealing with them. Participants from the East and North Coastal regions put less emphasis on Access & Services at 9.8% and 7.1% respectively, while those in North Inland emphasized this strongly at 31.8%. North Coastal forum participants favored Outreach & Support (17.9%) over these categories, looking particularly for more peer support groups to empower parents, students, and families.

Assessment, Prevention & Early Intervention also figured prominently at about 10% countywide and across regions, with a particular emphasis on children in the 0-5 age range expressed in the comments, including prenatal and postpartum assessments of mothers as a form of prevention. This category intersects with Access & Services and Education & Awareness in that many comments call for home, family, or school based screening and PEI services, as well as education both for awareness of signs and symptoms and for expanded implementation of preventative strategies in homes and schools.

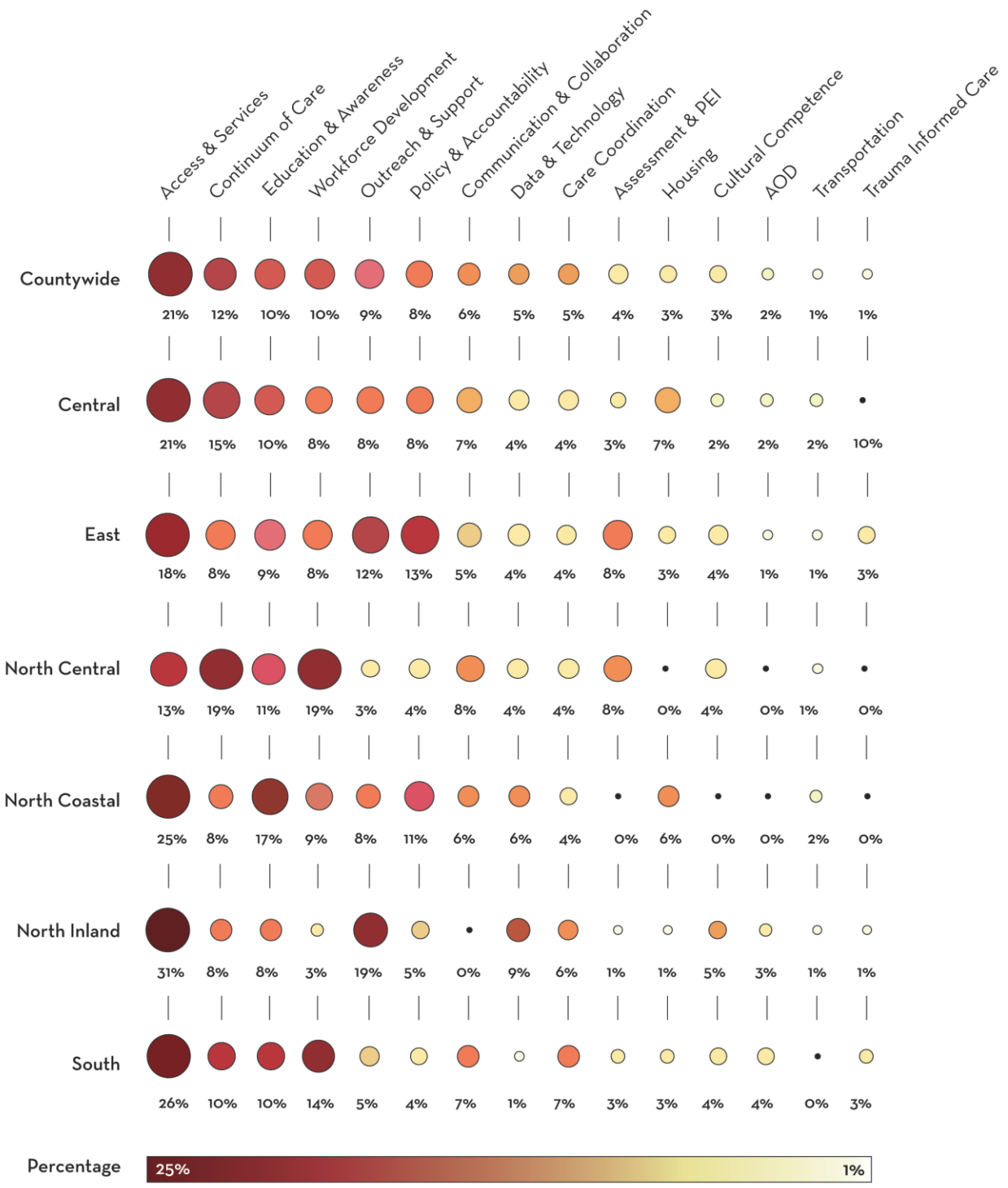
Comments across all categories focused on family-centered, community-based, peer-based, and intergenerational approaches to Children's Behavioral Health. Some notable steps suggested for optimizing Children's Behavioral Health include:

- Embedding behavioral health education into classroom curricula and school district trainings to increase awareness, decrease stigma, foster trauma-informed responses, and develop culturally competent skills
- Developing after school and extracurricular programs for education, awareness, support, and PEI with alternative approaches grounded in creative arts, music, gardens, fitness, and mindfulness
- Building community connections, collaborations, trust, and knowledge between parents, families, students, educators, and providers through conferences, forums, information and resource fairs, concerts, and other community events
- Developing a mobile technology toolbox for education, outreach, therapeutic services, and connecting clients to services, and also providing training to enhance the use of these tools by clients, case managers, and providers (mobile-technology toolbox?)

C. Care Coordination

Figure 5 maps the 15 Essential Themes within the topic of Care Coordination across the six HHSA service regions of San Diego County and indexes them against the county overall, revealing regional differences in prioritization of concerns.

Figure 5. Care Coordination by Region



Not surprisingly, Continuum of Care and Care Coordination are the top categories here, constituting about 1/3 of 711 comments across the County, with the exception of the East Region where they total only 25.7%. While the distinction between these categories might not have been fully observed by community participants, the prominent vision of a care continuum in this topic area suggests a need for

not only coordination of transitions between inpatient and outpatient services and behavioral and physical health resources, but also better coordination and integration of services within the Behavioral Health Systems of Care.

Workforce Development and Data & Technology also rank highly at about 10% each countywide, with variations from 7.5% North Inland to 17% North Coastal for the former and 2.5% North Inland to 18.9% North Central for the latter. These two categories combined weigh 30% among North Central participants. Despite variations in weight, comments across the county suggest the need for better training of providers, staff, and case managers to facilitate 'warm hand offs' and seamless integration across services, and also for the development of technologies for sharing data and streamlining paperwork. North Inland is a bit of an outlier here with participants putting more of an emphasis on Access & Services (18.8% compared to 9.3% countywide) than Workforce Development and Data & Technology combined (10% compared to 20.3% countywide), as is those in theEast Region, where the combined weight (25.7%) of Access & Services (12.4%) and Policy & Accountability (12.3%) equals the combined weight of Care Coordination (17.7%) and Continuum of Care (8.0%).

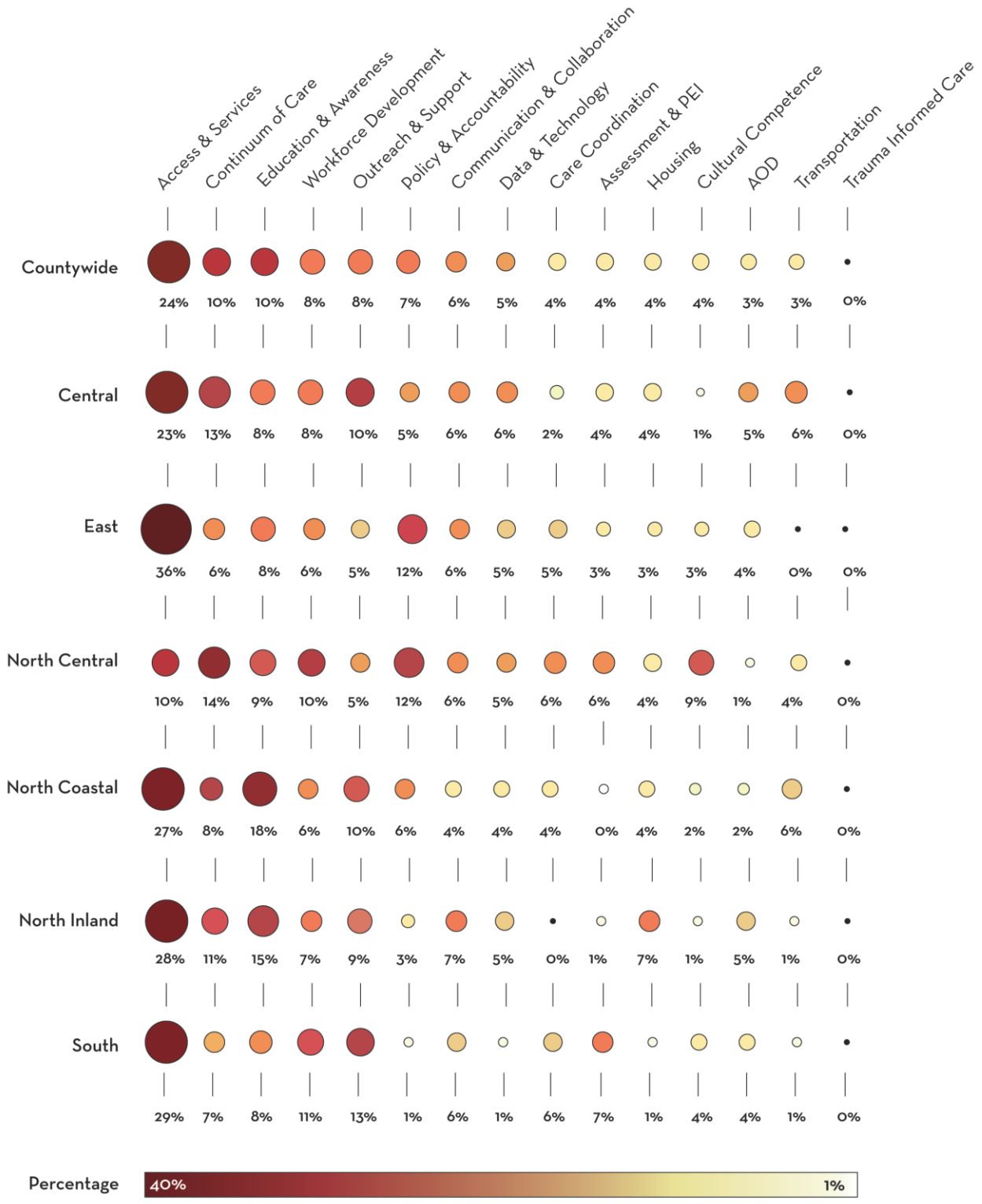
In particular, comments call for case managers to act as better advocates, liaisons, and system navigators for their clients, empowering them by connecting them to resources, assisting them with insurance claims and paperwork, and following up on referrals and transitions. They also call for the integration of information to facilitate consistency, communication, and tracking between clients, case managers, and medical and behavioral health providers, and for the centralization of services into regional hubs providing access to holistic care spanning behavioral and physical health needs. Generally, comments focus on client-driven, community-focused, team-based, and multidimensional approaches to Care Coordination. Some notable steps suggested for optimizing Care Coordination include:

- Establishing 'One Stop Shops' as a single point of entry and access, with triage coordinators, case management, and co-located behavioral health, physical health, and AOD services
- Creating an easily accessible central database to reduce duplication, streamline paperwork, and increase efficiency
- Increasing compensation, incentives, and recruitment, and decreasing caseloads to help maintain quality case management and improve staff retention
- Leveraging, expanding, and integrating existing services rather than creating new ones in order to avoid duplication and to improve efficiency

D. Unserved / Underserved Populations

Figure 6 maps the 15 Essential Themes within the topic of Unserved / Underserved Populations across the six HHSA service regions of San Diego County and indexes them against the county overall, revealing regional differences in prioritization of concerns.

Figure 6. Unserved/Underserved by Region



The community primarily envisioned increased access to culturally competent services for unserved and underserved populations (24% of 814 comments countywide), although in the North Central Region Education & Awareness took precedence at 13.5% of comments over 9.9% for Access & Services, and, in

East Region, Access & Services weighed in at 35.8%. Unserved and underserved populations identified by the community include: the homeless, undocumented immigrants, refugees, asylum-seekers, single parents, older adults, victims of domestic violence, torture survivors, justice-involved individuals, LGBTQI, TAY, foster youth, teen parents, Native Americans, and the deaf community. Across these populations, comments suggest not only a need for access to services, but also for increased education to expand awareness of behavioral health issues, indicators, and available services, and to promote tolerance and understanding. Teaching life skills and job training also stands out as an important educational task.

A vision of an improved Continuum of Care (10.1%), particularly prominent in the North Coastal (17.6%) and North Inland (14.7%) regions, emerges from numerous comments concerned with barriers, gaps, and waiting lists, jumping through hoops, wrong doors, and revolving doors. Workforce Development (8.2% countywide) focuses here on increasing staffing, training, and cultural competence to better serve the needs of those underserved populations identified. Housing ranks particularly high in this topic area at 8% countywide and 12.5% in the South. A significant need for Outreach & Support is expressed by participants at the East (11.9%) and North Central (12.1%) region forums, which reflects the needs of specific underserved population in those areas.

In general, comments focus on family-centered, community-based, and culturally appropriate approaches to better serving these populations. Some notable steps suggested for optimizing behavioral health for Unserved / Underserved Populations include:

- Developing mobile clinics that provide support, resources, and services for rural communities, families, the homeless, and homebound older adults
- Establishing regional 'One Stop Shops' that provide equal access to services by functioning as 'funnels' for unserved populations to enter into the behavioral health system
- Increasing temporary, transitional, emergency, and long-term housing by utilizing land in unincorporated areas, PODS, decommissioned ships, tiny homes, and multi-family housing, offering incentives to landlords, and partnering with Habitat for Humanity
- Increasing community outreach, education, and partnerships to create culturally embedded and knowledgeable behavioral health advocates, champions, and peer support groups

E. Innovation Projects

The Mental Health Services Act (MHSA) requires San Diego County to spend 5% of its MHSA funding on Innovation programs. Participants in the Conversation Cafés were given a handout to explain the requirements of MHSA Innovation project funding, and were presented four in-process BHS Innovation concepts. Participants discussed these proposed innovations in terms of similarity to existing programs and whether there was actually a need for what they would provide. A consensus was gathered from each table during the harvest. All of the projects were determined to be needed, although there were some exceptions and comments that were shared.

- ***Tele-Mental Health*.** 25% of the participants stated that the program was not a good use of funding and that similar programs already exist. 50% mentioned that the program would be more appropriate if offered in existing facilities or combined with the mobile ROAM project. Native American community members expressed this might be a good way to have culturally appropriate services in the rural areas of the southern reservations. Other participants felt that the Tele-Mental

Health program would be appropriate in rural and geographically isolated communities, e.g. Borrego, and refugee and Native American communities where culturally competent providers are scarce.

- ***Roaming Outpatient Assessment Mobile (ROAM)*.** Participants expressed that ROAM services would need to be embedded with regular physical health services in order to reduce stigma attached to mental health services provided by a mobile unit. Many stated that ROAM would be best coupled with Tele-Mental Health to optimize services. They also mentioned BHS' In-home Outpatient Treatment (IHOT) program and suggested that community members with lived experience could help staff the unit to make services more acceptable, and also that appropriate marketing could help reduce the stigma.
- ***Postpartum Depression Prevention and Intervention*.** This was one area that everyone agreed was a priority, and many suggestions were given about how the services could be integrated. Public Health Nurses were seen as viable educators who were also able to do home visits. Incorporating prevention education during regular OB/GYN visits and prenatal WIC programs was suggested. Participants felt it was important that the services be billable and possibly offered in-home. They also expressed the program should focus not only on the whole family, but also on traditional care givers such as grandparents or neighbors.
- ***Recuperative Bridge Housing*.** Recuperative Bridge Housing was determined to be the most needed project. Similar programs might exist, but participants suggested that the idea could be more innovative if coupled with variations in the housing, extended family, and whole family services. Using tiny houses and decommissioned ships was also mentioned. Several examples of similar programs given were Second Chance, Veteran's Village, and Kinship Housing, but these programs do not contain all the services of the proposed innovation, and they do not have enough capacity to meet need. The most common comment was that the program needs to be extended to at least 6 months or longer.

F. Parking Lot

Due to the change in the format of the forums this year, a 'Parking Lot' was established where people could register issues or ideas not discussed in the context of the three forum topics or captured in the harvest. Most of these repeated comments were captured in Table or Harvest data, likely because participants felt that the more times the issue was mentioned, the more funding it would attract.

In addition, several groups submitted extensive minutes from meetings that were conducted as part of BHS other community engagement activities. These notes suggested ways of targeting the needs of particular populations. The refugee community, for example, expressed the need for specific mental health assessment for newly arrived refugees and children. Other community-based agencies held similar group meetings to which they invited clients to address their specific issues with mental health. This input was not included in the process but the material was reviewed and considered for this report.

IV. SPECIAL GROUPS

Special Groups were conducted to meet the needs of populations previously identified in the community engagement process or that surfaced in the interim as needing more targeted and focused attention.

A total of six special group meetings were held. This section summarizes of these meetings: Table A provides an overview of meeting logistics, and Table B provides suggested strategies and examples of actionable solutions. The full reports can be found in Appendices E through J.

Table A. Special Groups Overview

Focus Community or Population	Meeting Purpose or Focus Topic	Location of Meeting	Number and Description of Participants
Justice Partners	Justice involved clients who have behavioral health concerns	San Diego County Hall of Justice	38 individuals participated in the Justice Partners Solutions Forum: Cross-sector leaders and staff from juvenile and adult systems represented within the County Public Safety Planning Group
Peer Workers	Role of Peer Workforce in behavioral health services	San Diego NAMI office	12 individuals participated in the Peer Worker Focus Group who were Peer workers with lived experience that is the same or like those being served by County HHSA-funded programs (Child/youth and adult systems and mental health and AOD); Eight non-profit organizations were represented
Southeastern San Diego community	Children's Behavioral Health concerns	CARE Center	15 individuals participated in this community conversation: 11 residents and/or individuals providing community-based services within Southeastern San Diego and 4 representatives from County Behavioral Health Services
Native American community	Native American behavioral health concerns	Indian Health Council (Rincon office)	34 leaders and staff from community-based organizations working with children, youth, families, and individuals participated in this community conversation. The majority, if not all, were Native American
Male Inmates	Community re-entry	George H. Bailey Detention Facility	11 low-risk, non-violent male inmates. Most were repeat offenders. Participants were recruited from a GED class and diverse in age and ethnicity: low 20's to late 50's and representatives from all major ethnic/racial groups
Female Inmates	Community re-entry	Las Colinas Detention and Reentry Facility	6 female inmates, most were repeat offenders; participants represented diverse ethnic groups

Promising Practices and Approaches. The following best practices or approaches were proposed by one or more groups:

- Trauma-informed care
- One-stop shops/no wrong door
- Culturally competent programs
- Stigma reduction Recovery-oriented care
- "One Brain" approach
- Inter-generational approach
- Early intervention
- Peer navigators and/or cultural brokers
- Restorative justice
- Whole Person approach
- Care integration

Table B. Summary of Strategies and Examples of Suggested Actionable Solutions

Focus Community or Population	**Strategies**	**Examples of Suggested Actionable Solutions**
Justice Partners	• Build capacity of all those engaged in providing services • Support system and services integration and improvement • Provide improved access to needed behavioral health treatment and services • Address other barriers to success such as housing instability, employment, transportation etc.	• *Bridge the cultures of clinical and criminal justice* • *Develop screening and triage for high risk youth* • *Provide cross-sector training that more clearly defines and describes the target populations to ensure that service providers*
Peer Workforce	• Support and build capacity of this workforce • Address systemic challenges that impact the effectiveness of peer-led services • Explore innovative ways of reaching and serving people • Reduce barriers that prevent or make it difficult for people to access services • Enhance school-based PEI services	• *Allow for integration at the service delivery level – considerable frustration at how services are currently in siloes.* • *Develop materials that illustrate career pathways for Peer Workers*
Southeastern San Diego community	• Create a working framework for real change • Utilize a strength-based approach that builds upon existing community assets • Provide accessible youth-friendly services • Support parents and grandparents	• *Provide ongoing training on trauma and ACE – not one-time efforts* • *Support on campus suspensions –keep youth in school*
Native American community	• Connect, inform and address misconceptions • Think outside the box – be innovative and resourceful • Eliminate barriers to behavioral health services • Address the impact of intergenerational trauma with an array of services and supports	• *Be proactive in facilitating Native American engagement with BHS – "don't leave us out of the conversation"* • *Use Positive Indian Parenting as a culturally specific program*

Male Inmates	• Provide services that support transition prior to release or immediately upon release • Help ex-offenders re-enter the job market • Advocate for system change that can reduce homelessness among ex-offenders • Provide access to drug treatment programs	• *Provide education on types of employment that are open to ex-offenders* • *Create ways for potential employers to come face to face with ex-offenders*
Female Inmates	• There is room to enhance pre-release and re-entry programs • Provide community services that address challenges to reentry and reduce the risk of recidivism. • Provide more support for the transition with the transition from jail to community, especially with those dealing with Mental Health and co-occurring disorders.	• *Provide InReach services earlier after re-entry* • *Reduce paperwork burden.* • *Address needs for women after release to the community and ongoing.*

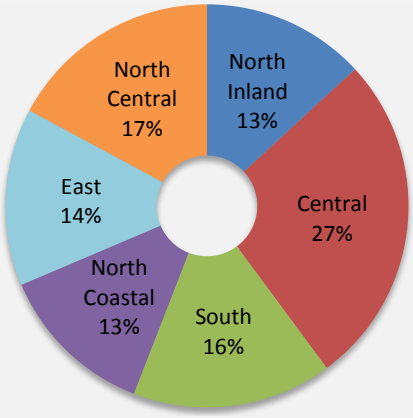
APPENDIX A. FORUM FEEDBACK

The County of San Diego division of Behavioral Health Services conducted 12 Conversation Cafés to engage the community in planning services to meet needs across age groups in the areas of Unserved and Underserved populations, Children's Behavioral Health, and Care Coordination. The process asked the community to envision a future for BHS, identify next steps, and explore proposed Innovation projects for the upcoming year. Forum feedback was gathered at all forums and is summarized below.

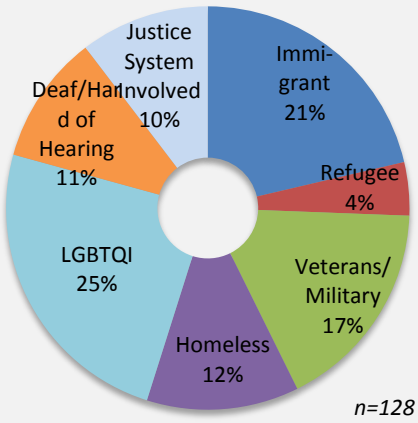
Feedback Responses by Region

553 Total Community Conversation Participants

449 Forum Feedback Forms *(80% response rate)*



Participants by Special Populations



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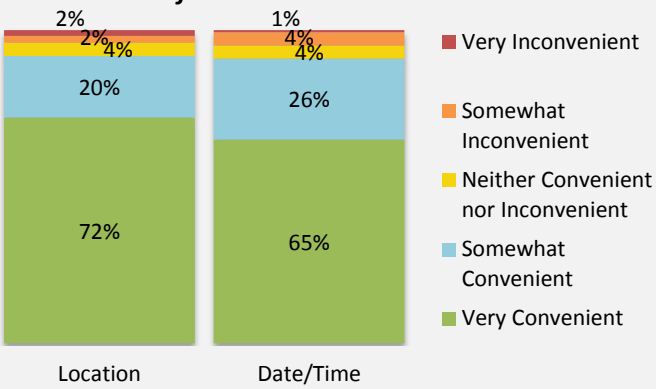
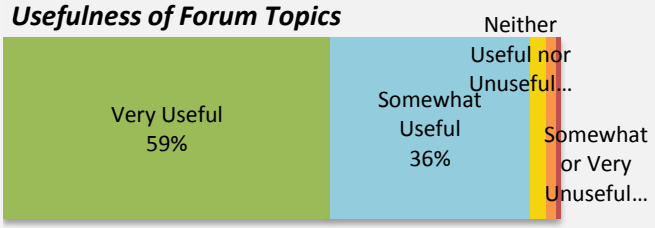
Convenience of Forum

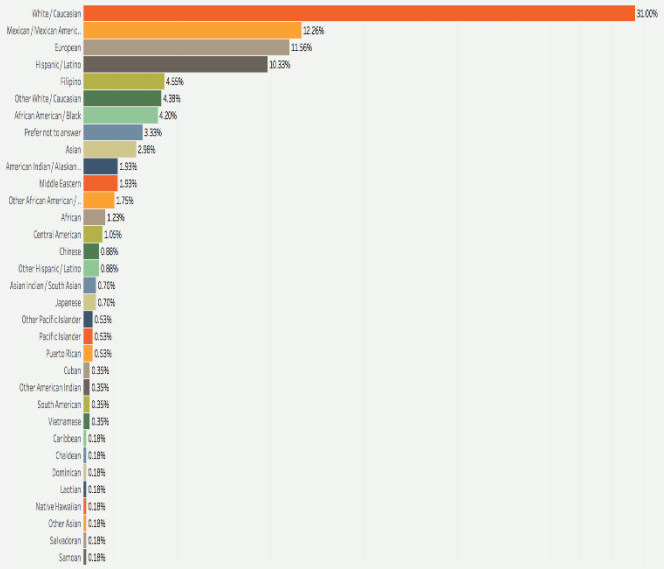


Usefulness of Forum Topics



Overall Quality of Forum

Ethnicity



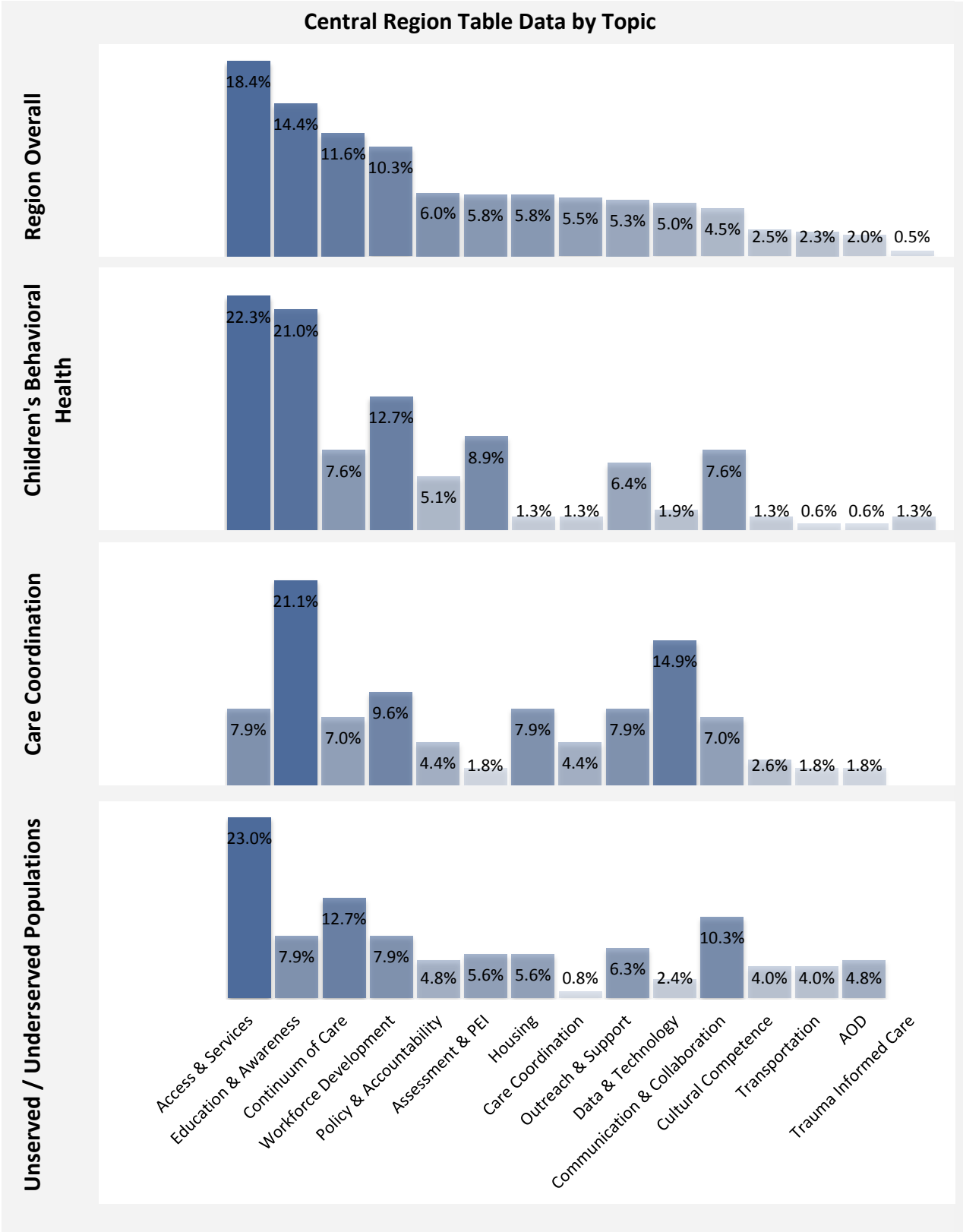
APPENDIX B. PARKING LOT DATA

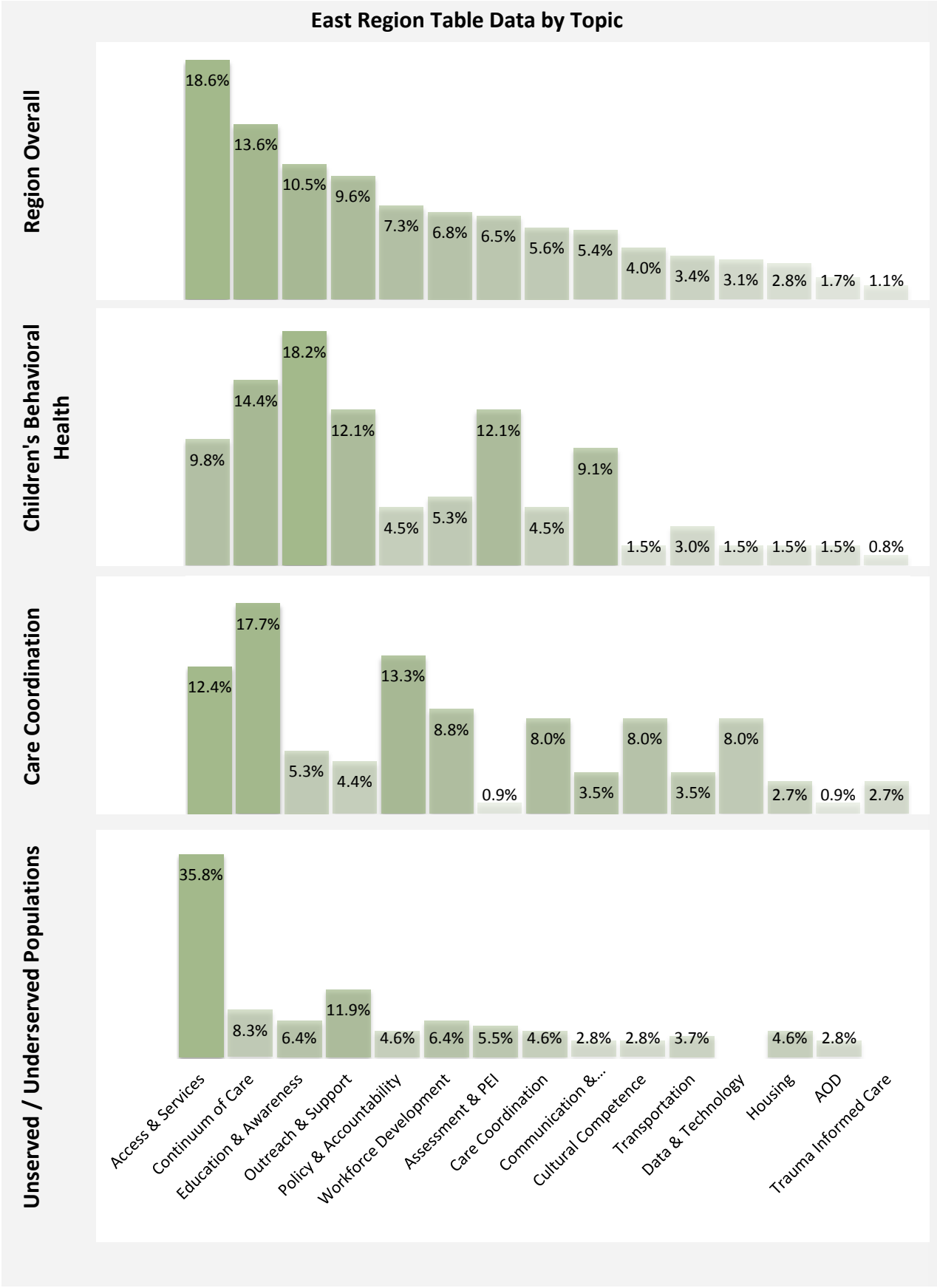
- Stop overmedicating, treat the whole person, practitioners are drug oriented
- Increase staff salaries
- Homeless people need housing not meds
- Incentives for psychiatrists
- Prevention and early intervention for veterans prior to discharge and support for families during transition
- Collaboration with existing organizations that serve specific populations to reach individuals whose culture makes accessing BHS difficult
- Partnering/augmenting home visiting adding early childhood mental health programs
- Culturally competent continuum of care for East African communities
- Residential services for men with children
- Caregiver mental health services in same place as children's behavioral health services
- Increased/improved senior behavioral health services
- Caregiver mental health services in same place as children's behavioral health services
- Increased/improved senior behavioral health services
- Provide similar forum farther into East County
- Post-partum longer-term support "nurse partnership program"
- Separate AOD from BHS
- Project evaluation instead of just data collection
- More opportunities to hire professional consultants not just employees
- Allow applicants to bid on RFP, not just regions
- Fund non-traditional MH programs like art and cultural therapy
- More clubhouses in South Bay & increase funding for existing clubhouses in SB
- More services for deaf and hard of hearing
- Incentive program for college students to pursue BHS careers
- More publicity around forums like this to demonstrate to community the care and thought that goes into decision making
- Substance abuse detox services provided immediately upon request
- Long term live-in facility for teens with addiction issues with school and counseling included
- WRAP program works
- Increase aftercare services
- Rideshare incentives to transport people with MH disabilities
- Rideshare tax used to fund programs for adults and children
- Engage bars and restaurants to donate as a PR opportunity
- Income support and work training woven through all programs
- Eliminate time restrictions for treatment
- Better integration of physical and mental health
- Multidisciplinary team approach
- Better electronic health record sharing

APPENDIX C. ESSENTIAL THEMES

- **Access & Services:** Comments envisioning improved access to, and expansion of programs and services, as well as suggestions such as more mobile, in-home, and school-based services.
- **AOD:** Specifically, comments pertaining to alcohol and drug treatment programs and services, AOD education and awareness, and the integration of AOD and Mental Health services.
- **Assessment, Prevention & Early Intervention:** Comments calling for earlier assessment and the development and expansion of preventative education and intervention programs.
- **Care Coordination:** Specifically, comments pertaining to the coordination of mental and physical health, transitions between inpatient and outpatient care, and re-entry from the justice system.
- **Communication & Collaboration:** Comments calling for better communication and collaboration between clinics, providers, schools, parents, the county, law enforcement, and community organizations.
- **Continuum of Care:** Comments suggesting better coordination and integration of services and improved case management to close gaps and to help clients navigate the system.
- **Cultural Competence:** Comments calling for more cultural awareness, education, training, and language proficiency to help serve diverse populations.
- **Data & Technology:** Both comments expressing a need for a centralized, integrated, and accessible database to facilitate communication and coordination, and comments suggesting the use of technologies for education, outreach, and service provision.
- **Housing:** Comments envisioning more temporary, transitional, emergency, long-term, and full service housing, and also suggestions for alternative housing solutions.
- **Outreach & Support:** Comments calling either for community outreach campaigns and events to meet people where they are, expand awareness, and build trust, or for the development of more peer support groups, programs, and services.
- **Policy & Accountability:** Specific to comments about changing requirements, laws, or policies to make access easier, or comments calling for better assessment of programs and providers.
- **Education & Awareness:** Comments suggesting better education for teachers, families, students, and communities to increase awareness of behavioral health issues and indicators, to destigmatize these issues, and to teach skills for dealing with them.
- **Transportation:** Mostly comments calling for transportation services to help clients access services.
- **Trauma Informed Care:** Comments that specifically mention the need for treatment to be sensitive to traumatized clients, or call for education and training in this area.
- **Workforce Development:** Comments envisioning an improved and expanded behavioral health workforce and suggesting increased recruitment, salaries, incentives, and training, and reduced caseloads, to facilitate staff retention, better service provision, and improved case management.

APPENDIX D. TABLE DATA BY REGION




East Region Table Data by Topic
Region Overall
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13.6%
10.5%
9.6%
7.3%
6.8%
6.5%
5.6%
5.4%
4.0%
3.4%
3.1%
2.8%
1.7%
1.1%
Children's Behavioral Health
9.8%
14.4%
18.2%
12.1%
4.5%
5.3%
12.1%
4.5%
9.1%
1.5%
3.0%
1.5%
1.5%
1.5%
0.8%
Care Coordination
12.4%
17.7%
5.3%
4.4%
13.3%
8.8%
0.9%
8.0%
3.5%
8.0%
3.5%
8.0%
2.7%
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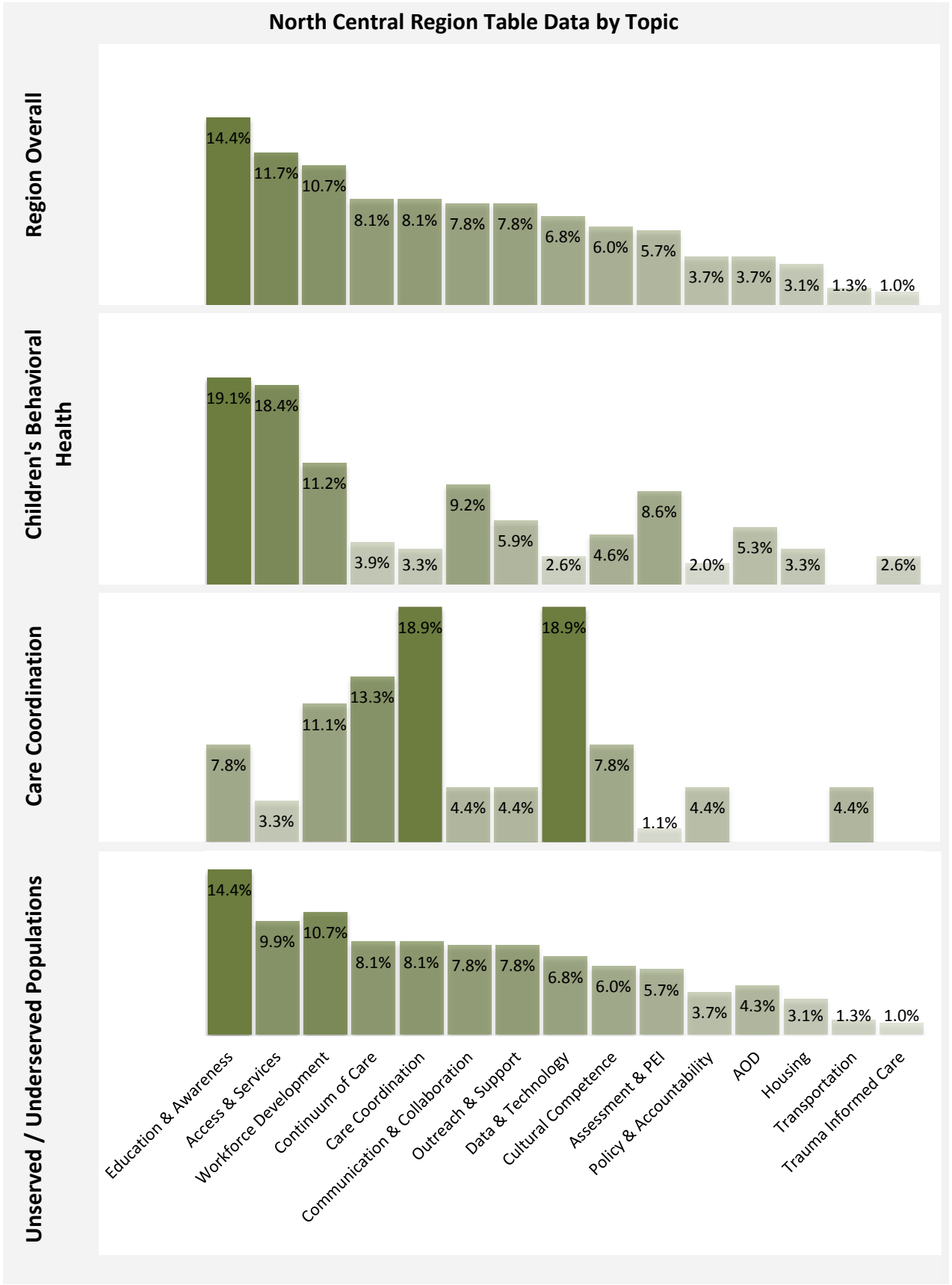
2.7%
Unserved / Underserved Populations
35.8%
8.3%
6.4%
11.9%
4.6%
6.4%
5.5%
4.6%
2.8%
2.8%
3.7%
4.6%
2.8%
Access & Services
Continuum of Care
Education & Awareness
Outreach & Support
Policy & Accountability
Workforce Development
Assessment & PEI
Care Coordination
Communication &...
Cultural Competence
Transportation
Data & Technology
Housing
AOD
Trauma Informed Care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Region Overall
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8.1%
7.8%
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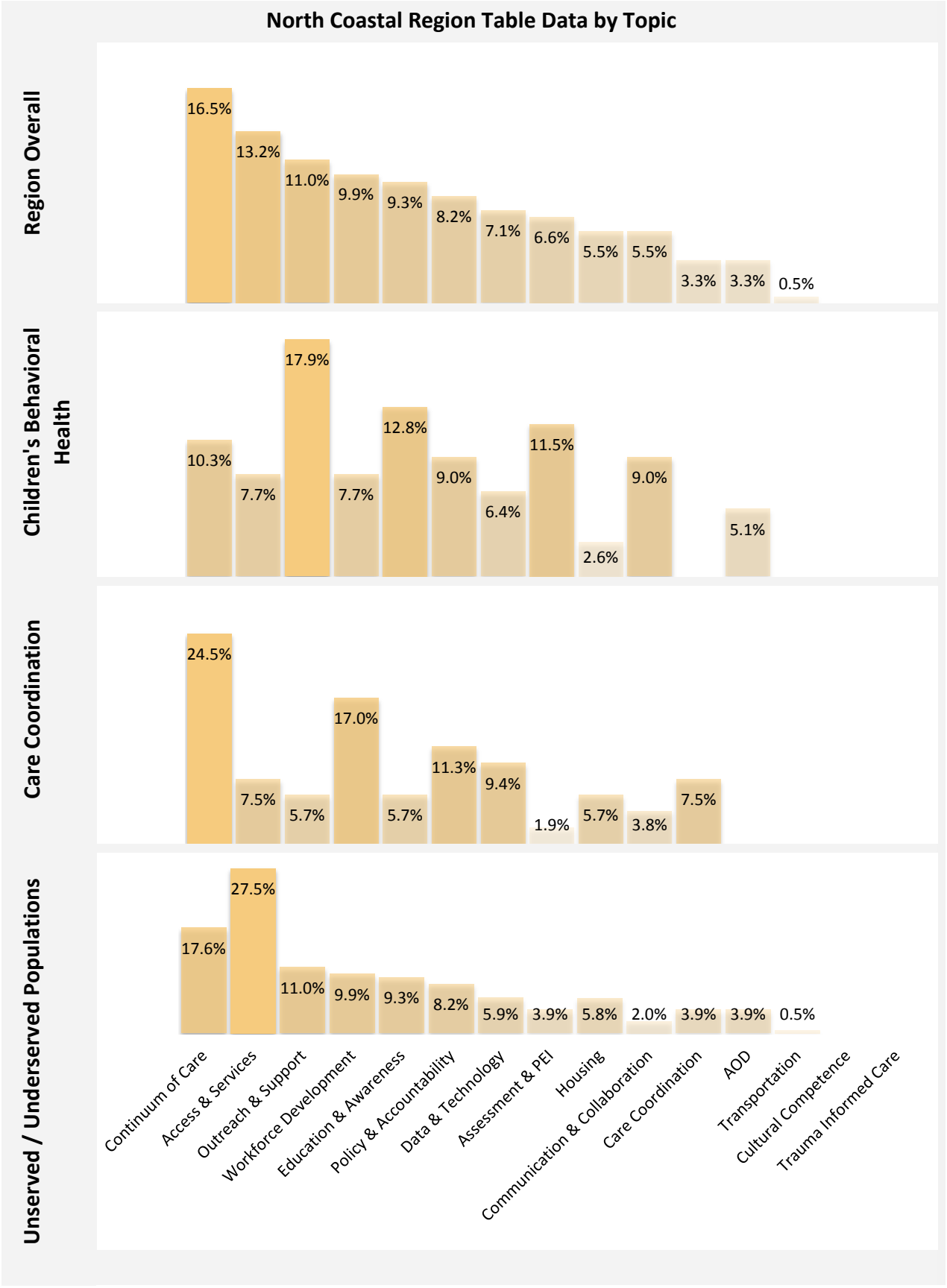
6.0%
5.7%
3.7%
3.7%
3.1%
1.3%
1.0%
Children's Behavioral Health
19.1%
18.4%
11.2%
3.9%
3.3%
9.2%
5.9%
2.6%
4.6%
8.6%
2.0%
5.3%
3.3%
2.6%
Care Coordination
7.8%
3.3%
11.1%
13.3%
18.9%
4.4%
4.4%
18.9%
7.8%
1.1%
4.4%
4.4%
Unserved / Underserved Populations
14.4%
9.9%
10.7%
8.1%
8.1%
7.8%
7.8%
6.8%
6.0%
5.7%
3.7%
4.3%
3.1%
1.3%
1.0%
Education & Awareness
Access & Services
Workforce Development
Continuum of Care
Care Coordination
Communication & Collaboration
Outreach & Support
Data & Technology
Cultural Competence
Assessment & PEI
Policy & Accountability
AOD
Housing
Transportation
Trauma Informed Care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9.9%
9.3%
8.2%
7.1%
6.6%
5.5%
5.5%
3.3%
3.3%
0.5%
Children's Behavioral Health
10.3%
7.7%
17.9%
7.7%
12.8%
9.0%
6.4%
11.5%
2.6%
9.0%
5.1%
Care Coordination
24.5%
7.5%
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17.0%
5.7%
11.3%
9.4%
1.9%
5.7%
3.8%
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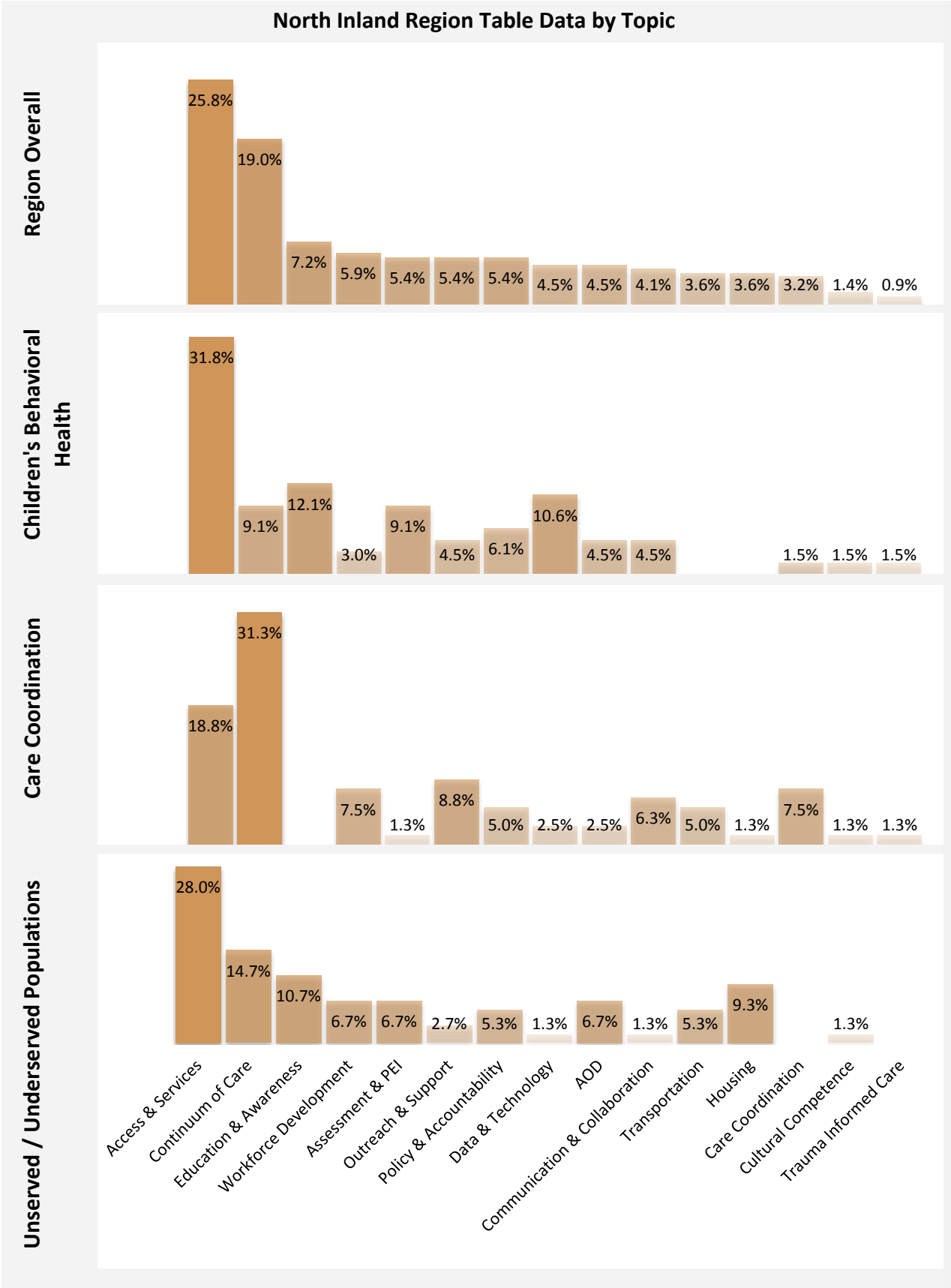
Unserved / Underserved Populations
17.6%
27.5%
11.0%
9.9%
9.3%
8.2%
5.9%
3.9%
5.8%
2.0%
3.9%
3.9%
0.5%
Continuum of Care
Access & Services
Outreach & Support
Workforce Development
Education & Awareness
Policy & Accountability
Data & Technology
Assessment & PEI
Housing
Communication & Collaboration
Care Coordination
AOD
Transportation
Cultural Competence
Trauma Informed Care


North Inland Region Table Data by Topic
Region Overall
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7.2%
5.9%
5.4%
5.4%
5.4%
4.5%
4.5%
4.1%
3.6%
3.6%
3.2%
1.4%
0.9%
Children's Behavioral Health
31.8%
9.1%
12.1%
3.0%
9.1%
4.5%
6.1%
10.6%
4.5%
4.5%
1.5%
1.5%
1.5%
Care Coordination
18.8%
31.3%
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1.3%
8.8%
5.0%
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5.0%
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7.5%
1.3%
1.3%
Unserved / Underserved Populations
28.0%
14.7%
10.7%
6.7%
6.7%
2.7%
5.3%
1.3%
6.7%
1.3%
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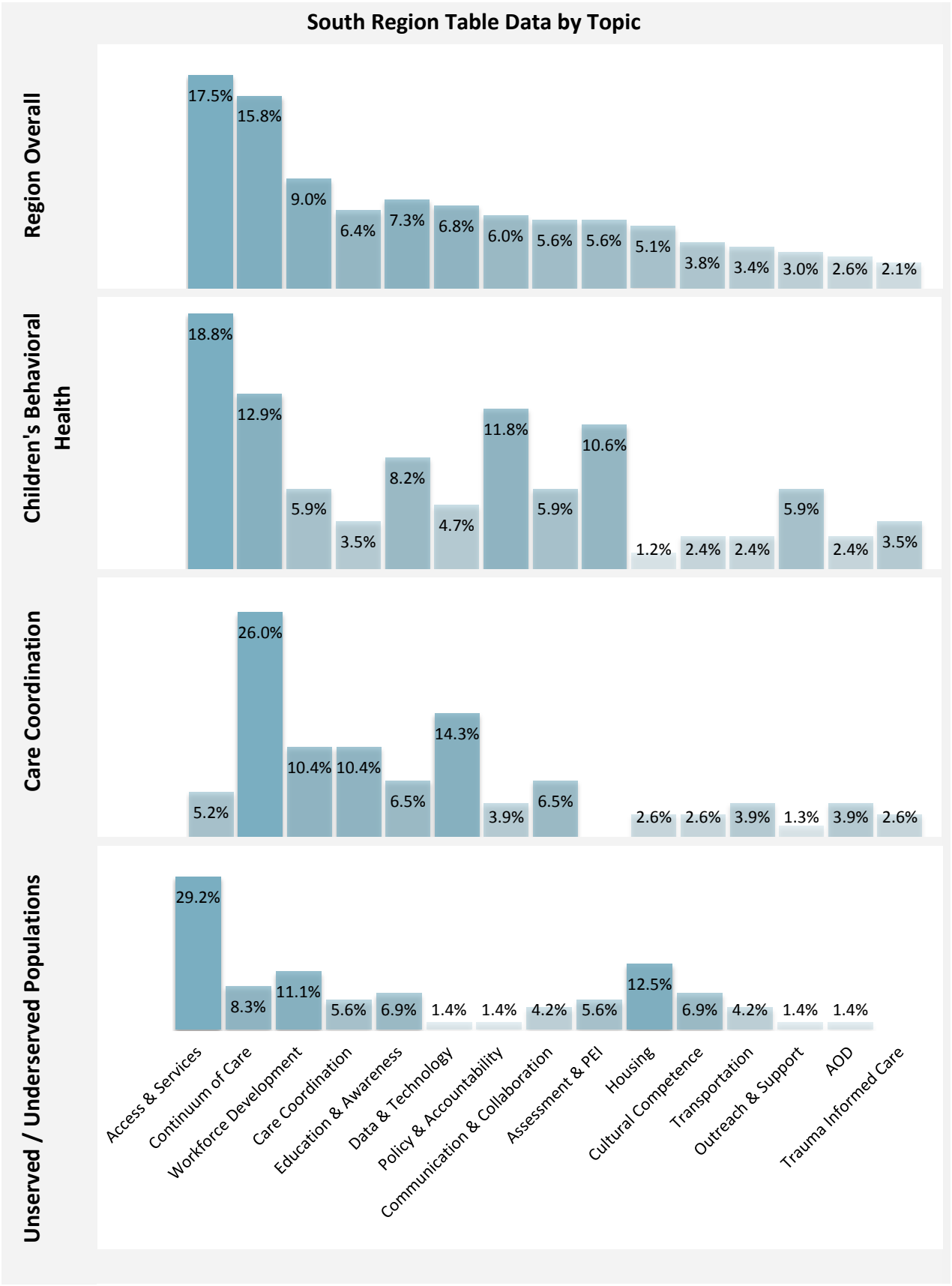
Access & Services
Continuum of Care
Education & Awareness
Workforce Development
Assessment & PEI
Outreach & Support
Policy & Accountability
Data & Technology
AOD
Communication & Collaboration
Transportation
Housing
Care Coordination
Cultural Competence
Trauma Informed Care


South Region Table Data by Topic
Region Overall
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9.0%
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5.6%
5.6%
5.1%
3.8%
3.4%
3.0%
2.6%
2.1%
Children's Behavioral Health
18.8%
12.9%
5.9%
3.5%
8.2%
4.7%
11.8%
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10.6%
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2.4%
2.4%
5.9%
2.4%
3.5%
Care Coordination
5.2%
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10.4%
6.5%
14.3%
3.9%
6.5%
2.6%
2.6%
3.9%
1.3%
3.9%
2.6%
Unserved / Underserved Populations
29.2%
8.3%
11.1%
5.6%
6.9%
1.4%
1.4%
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1.4%
Access & Services
Continuum of Care
Workforce Development
Care Coordination
Education & Awareness
Data & Technology
Policy & Accountability
Communication & Collaboration
Assessment & PEI
Housing
Cultural Competence
Transportation
Outreach & Support
AOD
Trauma Informed Care

APPENDIX E. JUSTICE PARTNERS FORUM REPORT

Overview. Attendees at the Justice Partners Solutions Forum were cross sector leaders and staff from juvenile and adult systems (n=38) represented within the County Public Safety Planning Group. This special focus group was held at the Hall of Justice.

Process. The process used was a planning forum format in which attendees were separated into four groups: one juvenile and three adult focused. Each group was tasked with: a) reviewing outcomes; b) identifying needs and gaps; c) agreeing upon actionable solutions and strategies that meet the goal "We are more fully meeting the needs of justice involved clients who have behavioral health concerns".

General Themes: The overarching call for action that emerged from this planning session is for services across the spectrum of care to: prevent engagement of children with behavioral health needs in the criminal justice system; reduce recidivism among both juveniles and adults; and support community re-entry and family unity.

Findings. The following gaps and unmet needs in services or provider capacity were identified:

Within Juvenile Justice Partners groups:

1. **Ability to meet the demand for services.** Participants discussed gaps in capacity from the perspective of a lack of programs or services to meet the need, as well as problems recruiting staff to fill vacant positions. One of the suggested causes for unfilled vacancies was the pay structure (understood to mean that the compensation offered may not be competitive enough). Gaps in ability to provide bilingual services were also referenced. Specific service gaps identified by the juvenile group were:
    - prevention and early intervention services
    - gender-specific and age-specific treatment
    - dual-diagnosis treatment services
    - placement beds (i.e. for youth with mental health and/or AOD diagnosis)
    - transportation
    - insufficient insurance
2. **Awareness, knowledge and skill of those tasked with providing services.** Participants called out a need for training that would raise overall mental health awareness among law enforcement to ensure cultural competency and to improve understanding of acute mental health symptoms among younger children (i.e. 4th and 5th grade). The group also suggested a need for more comprehensive assessment of treatment providers.

Within the Adult Justice Partners groups:

1. **Insufficient availability of services.** Participants suggested that there are not enough services, including:
    - treatment beds
    - AOD and/or mental health treatment programs
    - therapeutic services
    - housing support
    - transportation services

- case management, care-coordination or system navigation (with those who don't qualify for ACT services specifically called out)

2. **Capacity of providers to meet the needs of the target population.** This was presented as a training and professional development gap. Service providers need an understanding of the target population and criminogenic needs and the law enforcement/justice community needs an understanding of behavioral health challenges and the impact of trauma.
3. **Quality of assessment process.** All three groups referenced a need to improve assessment or screening practices and for tools or approaches that target the right services to the right people at the right time.
4. **Integration across systems.** Gaps and needs in this area included the need to have a shared language and the ability to coordinate between the justice and service systems at different points and times.

Summary of promising practices or approaches that were suggested by one or more group:

- Trauma informed care
- Recovery-oriented
- Export best-practices (i.e. from cities of Los Angeles and Miami)
- Coordinated regional approach
- Innovate
- "Anything other than jail"
- Integration of custody/supervision and clinical services (criminal justice and behavioral health systems)

Strategies and Suggested Actionable Solutions. The suggested solutions and strategies were clustered under broad strategic directions. Items with a * are those that were also suggested by inmates who participated in focus groups at either George Bailey (men) or Los Colinas (women) Detention Facility along with other ideas (see companion report).

Strategy	Suggested Actionable Solutions
1. Build capacity of all those engaged in providing services	• *Provide cross-sector training that more clearly defines and describes the target populations to ensure that service providers understand criminogenic needs and characteristics and justice/law enforcement understand impact of trauma, mental health and co-occurring disorders* • *Train teachers and counselors about behavioral health needs with a focus on 4th to 8th grade* • *Breakdown the distinction between misdemeanor and felony*

2. Support system and services integration and improvement	• *Bridge the cultures of clinical and criminal justice practices* • *Assess why there are underutilized programs ("not willing to fill space or do the work")* • *Implement an anti-stigma campaign aimed to support reintegration of individuals with criminal justice history into community** • *Maintain an updated menu of available treatment options aligned with risk factors – provide to judges and prison counselors** • *Sustain collaborative approaches (BH Court, drug court)* • *Expand 211 contract to include tracking of resources for mental health beds/placement* • *Use waiting time to be processed into jail to complete a checklist of other needs to ID clients*
3. Provide improved access to needed behavioral health treatment and services	• *Develop a way to screen, triage, so highest risk youth are frontloaded for diversion services* • *Establish geographically-based coordination and assessment centers** • *Create a Multi-Disciplinary Team for high users in other HHSA programs (as a diversion/prevention approach)* • *Understand increased risk for criminal behavior among individuals with co-occurring disorders i.e. increases rates of resisting arrest* • *Develop PAARI/SMART/LEAD type programs that are holistic (treatment, housing and wrap services)* • *Expand dual diagnosis services* • *Work with Community Care Licensing for juvenile placement strategies* • *Use LPS facilities for hospitalizations for those with insurance* • *Under Prop 47, clients will voluntarily identify services that they need – need to determine how to incentivize them to accessing treatment*
4. Address other barriers to success such as housing instability, employment, transportation etc.	• *Expand the Cool Bed program for youth, offer incentives to landlords* • *Expand juvenile diversion and mentoring services* • *Provide care coordination and housing navigation services for all populations - youth, families, and adults* • *Establish in-custody assessment team to support transition planning and linkage to community services prior to release (treatment services, SSI benefits)* • *Design employment programs specifically for justice involved populations** • *Create a central coordination system and incentivize inmates to go directly to this service upon release** • *Address transportation needs** • *Expand ACT Program capacity* • *Provide more re-entry housing** • *Encourage peer engagement and volunteerism through clubhouses* • *Support mentoring and peer-based services for adults**

APPENDIX F. NATIVE AMERICAN COMMUNITY CONVERSATION REPORT

Overview. Attendees at this community conversation were representatives from Native American communities within San Diego County (n=34). The majority of participants were leaders or staff from community-based organizations and programs that are working with children, youth, families, and individuals. Several Native American consumers who reside on represented reservations were also present. This special focus meeting was conducted at the Rincon offices of the Indian Health Council, which also assisted with community outreach.

Process. A guided two-way conversation structured around four key questions:

- What would be good for people to know about Native American communities?
- What is currently working for Native American families around behavioral health?
- What are the most pressing needs of Native American communities when it comes to behavioral health?
- What ideas or suggestions do you have for approaches or practices that could make the best and biggest difference in improving behavioral health outcomes for Native American communities?

Attendees then broke into smaller groups to create graphic depictions of their responses to questions 2, 3 and 4.

General Themes. In addition to discussing strategies to improve behavioral health outcomes, participants also discussed factors that need to be considered when providing behavioral health services to Native American communities. These factors include: culture, history, geography (with many communities located in remote regions), and socio-economics such as poverty, unemployment and poor housing quality.

Findings. Things to be considered and acknowledged when working with Native American communities:

1. **There is a perception within this community that Native Americans are marginalized and that their needs and strengths are not fully understood.** It was noted that Native America communities experience the same types of behavioral health issues as other communities, but there are unique factors that need to be considered when developing services:
    - Geographic isolation makes it difficult to access services that are not provided within the community; many members live on unpaved roads and some tribes are located miles away from any kind of service.
    - The tight knit structure of Native American communities and families means that problems are less hidden and can impact a greater number of people (beyond immediate family members). This makes it important to have services that address the needs of family and community, not just the individual with the presenting mental illness or substance abuse problem.
    - There are 18 different tribes in San Diego County, and they are each unique with regards to history, cultural practices and access to resources. The “Casino Money Myth” is especially problematic: casinos are not funding tribal programs and there is not an excess of money.

- Historical and intergeneration trauma due to the legacy of Indian Boarding Schools, loss of land, breakdown of families, and erosion of culture are considered root causes of behavioral health issues. Providers who are working with Native American communities (including Native American and non-Native American staff) need access to training in trauma informed care that is culturally specific.

2. **Culture is important and needs to be woven into all efforts.** The group discussed how cultural values can both hinder and aid in the establishment of good mental health and sobriety. Also consider how some of these values are complex, contradictory, and not always uniform. Values that were referenced were: desire for privacy especially with regards to problems; tolerance; connection to family and community (makes it difficult to leave); respect for elders.
3. **There is a stated desire for greater engagement and connection to strengthen native-nonnative bonds.** Participants would like greater access to BHS staff, fewer restrictions on use of funding, consistency in accountability, and opportunities to work more closely with non-American Native providers. Also, for there to be efforts to have greater representation of Native Americans as staff, on committees, at training events.
4. **Unserved/underserved groups were identified.** The following groups with mental illness, substance abuse or dual diagnosis were called out as having unmet needs: individuals with disabilities; families with children with special needs; foster children and foster families (including grandparents); transition age youth including teen parents; individuals released from incarceration or placed on community supervision, and their families.

Summary of promising practices or approaches that were suggested by the group:

- "One Brain" approach
- No wrong door
- One stop shop
- Tele Health
- Alternative response teams
- Inter-generational
- Culture as prevention
- Arts for wellness
- Positive Indian Parenting

Strategies and Suggested Actionable Solutions

Strategy	Suggested Actionable Solutions
1. Connect, inform and address misconceptions	• *Be proactive in facilitating Native American engagement and representation with BHS – "don't leave us out of the conversation"* • *Involve the community in service design, including elders and youth* • *Allow Native American organizations to provide training to non-Native Americans on culture, history, and needs to support stronger relationships and cultural competency* • *Recruit Native Americans for careers in BHS* • *Explore how trauma is affecting the community*
2. Think outside the box – be innovative and resourceful	• *Incorporate Native American culture into prevention and treatment – arts, cultural initiatives and rites of passage, social events, youth/elder groups, "stitch to Wellness"* • *Train first responders in mental health (fire fighters and ambulance) so they can serve as alternative response teams* • *Use technology, i.e. telehealth program for follow-up to appointments* • *Community events and celebrations that promote sobriety, including ones focused on youth (such as Friday Night Live)* • *Create one-stop-shops for BHS and other resources including domestic violence services, family strengthening programs, and support for foster families* • *Confidential substance abuse/mental health info line or hotline for Native Americans* • *Establish a tribal foster facility to keep children within the community*
3. Eliminate barriers to behavioral health services	• *Adopt a "no wrong door" approach – people don't come in for BHS but that is what they need; have to be flexible* • *Wraparound services to address basic needs, i.e. for housing, transportation, and employment (culturally competent vocational education)* • *Provide specific education and outreach to address stigma and promote the "beauty of recovery" from a cultural perspective*
4. Address the impact of intergenerational trauma with an array of services and supports	• *Develop a re-entry program for formerly incarcerated individuals – include transitional housing and family therapy* • *Use treatment approaches that address family dynamics and strengthen family capacity to support recover, break cycles* • *Provide peer support/navigation, education, and classes to parents, partners, and families of individuals who are struggling with AOD and/or mental health and parents with children with special needs* • *Use Positive Indian Parenting as a culturally specific program* • *More funding for services that address co-occurring AOD and mental health in inpatient settings for youth and adults* • *Provide services for parents of children with special needs* • *Safety net services for Native American foster parents or grand parents*

APPENDIX G. PEER WORKER FOCUS GROUP REPORT

Overview. Attendees at this focus group were individuals (n=12) employed as peer workers, i.e. those with lived experience that is the same, or similar, to those being served within County HHSA- funded programs. Individuals from child/youth and adult systems as well as mental health and AOD programs were represented. A total of 8 non-profit organizations were represented. The group was held at the San Diego NAMI offices, and outreach assistance was provided by County BHS Contracting Officer Representatives (CORs).

Process. A traditional focus group format was used that centered around the following questions:

- Tell us about your work: what services or strategies do you use in in helping peers/families on the path to recovery that are especially successful?
- BHS has identified the following priority goals:
  - Reaching underserved/unserved populations
  - Improving children's behavioral health services
  - Improving care coordination

  What ideas do you have of ways to reach these goals? What do you think is already working? What challenges or gaps do you see – and how might you address them?
- What innovations or ideas do you have of things that could help make you even more effective in improving outcomes for peers/families?

General Themes. Participants shared their perspective as front-line workers who are serving as a bridge between underserved populations and the complex system of care. There was also discussion about what could be done to make the peer-based workforce more effective.

Findings. The following are general observations and highlights from the focus group.

- **Peer workers are providing highly valuable services and play a unique role in the BHS workforce**. All but two of the participants work directly with consumers (the other two work with NAMI and are coordinating trainings and building capacity) and were very passionate, informed and articulate. Peer workers are especially useful in facilitating access and maintaining engagement of difficult-to-reach and underserved populations who are often most in need of BHS services, such as homeless youth. This workforce has insights and experience that could be useful when designing programs and services.
- **There is a general sense of frustration with their working conditions**. There was agreement that the current reporting requirements are burdensome and attendees questioned whether the value is proportionate to the time spent. There is also concern that stresses associated with documentation are causing staff who are highly skilled in engaging with consumers to leave the workforce, e.g. "people aren't attracted to this type of work because they like paperwork." Other concerns related to the need for more training, mentoring, peer support, and opportunities for networking.
- **Many of the ideas put forward were actionable and pragmatic in nature**. Participants in this group wanted to spend less time on identifying needs and more time on problem solving. They were quick in coming up with ideas and building upon suggestions that ranged from big

visionary concepts of how to address homelessness, to requests for more accessible and consumer-friendly information on available services.

Summary of promising practices or approaches that were suggested by the group:

- Whole person approach
- Trauma informed
- Stigma reduction
- Early intervention
- One stop shops
- Care integration
- No wrong door

Strategies and Suggested Actionable Solutions

Strategy	Suggested Actionable Solutions
1. Support and build capacity of this workforce	• *Encourage HHSA contractors to provide meaningful self-care opportunities (pass to a gym or yoga class) to peer workers* • *Provide incentives or scholarships to attend trainings or certification courses* • *Develop materials that illustrate career pathways for peer workers* • *Allocate time for collaboration and networking with other organizations* • *Want peer support and mentoring opportunities*
2. Address systemic challenges that impact the effectiveness of peer-led services	• *Allow for integration at the service delivery level – there is considerable frustration at how services are currently siloed (i.e. a peer worker within a mental health program can't work with an individual who is receiving AOD services)* • *Make the process for completing progress notes more streamlined/easier - it takes at least 30 minutes to write progress notes after each contact (seen as a poor use of their time)* • *Create a Documentation Specialist position, and allow use of voice recognition software or simplify forms* • *Involve peer workers (users of data management systems) in the design so they can let you know if something is feasible and reasonable*
3. Explore innovative ways of reaching and serving people	• *Create kiosks/screens at trolley stations (e.g. 12th and Imperial) with interactive display of BHS services and videos* • *Establish one-stop-shops for mental health, AOD and public health – especially for populations like TAY and homeless (i.e. WELLNESS DEPOTS)* • *Establish a policy or procedure to make it possible for providers to create informational or educational videos featuring clients* • *Develop more consumer-friendly information on available services and programs and make available on County website and at places where target populations feel safe (e.g. libraries, community organizations, schools, clinics)*
4. Reduce barriers that prevent or make it difficult for people to access services	• *Keep the amount of bureaucracy, paperwork, and assessments to a minimum– try low barrier approaches (fewer eligibility requirements)* • *Allow for drop-in services, with a "no wrong-door" approach* • *Address the issue of transportation – provide more bus passes or have one-stop-shop (so people aren't going all over the place)*
5. Enhance school-based PEI services	• *Start reach-in programs before 4th grade* • *Support school-based programs that teach mindfulness* • *Provide more behavioral health specialists in schools to aid in prevention* • *Use a whole-person approach to wellness with children as well as with adults*

APPENDIX H. MALE INMATES FOCUS GROUP REPORT

Overview. The Male Inmates focus group was conducted with low risk, non-violent offenders (n=9) within the George Bailey Detention Facility operated by the County of San Diego Sherriff Department. Most participants were repeat offenders. Five participants were white, one was African American, and three were mixed race or Hispanic. Ages ranged from early 20's to late 50's. Participants had come from a GED class, so we can assume that none had graduated from high school. The meeting was observed by a counselor who also engaged in some trouble shooting around individual issues at the end of the session. The level of participation and engagement was very high.

Process. A structured but conversational format was used, using the following agenda:

1. Overview of meeting purpose - to gather information about what is needed to support successfully re-entry into community.
2. Brainstorm of major services and supports needed
3. Deeper discussions about specifically what types of services are needed, where the gaps and challenges are, and their ideas for how these gaps and challenges could be addressed.
4. Closing – which included a brief discussion with the Counselor of available services.

General Themes. The overarching theme for this group was how to prevent recidivism. Inmates were asked to discuss the challenges they face when trying to re-enter successfully into community once they are released.

Findings. The following are general reflections and highlights from the deeper discussions:

1. **Housing is a source of major concern.** The topic of housing provoked the greatest participation and vocal frustration. One of the younger inmates said that housing was more important than getting a job, he spoke about how without shelter you couldn't easily keep clean and you were at constant risk of being picked up by police. They all agreed that the first 72 hours after being released are make or break time. I asked if people typically knew where they were going to spend their first night after they were released and the response was "*no... many people have no idea.".*
2. **The task of reentry can be overwhelming and there is a fear of failure.** One of the inmates said that he was much more likely to get depressed and frustrated when he was out of jail than when he was inside. "*I spend a lot of time in here making plans about what I'm going to do when I'm released. I have all these ideas. But when you get out it's frustrating because you can't do it, there's too much in the way, so you just give up and go back to doing what you were doing that got you in here*". *"In here you have food and somewhere to sleep. Outside you have to take care of those things yourself and it's not easy*". In response to this last comment other inmates agreed and added *"If you are hungry, cold or tired you are going to make bad decisions."*
3. **Jobs are viewed as a key to success, but this an area that is fraught with barriers.** This was the topic that the inmates wanted to talk about first and where they had the most suggestions. They see employment as critical to successful re-entry, they need a way to make money and to be productive.
4. **Further exploration of behavioral health services is warranted.** The discussions of mental health and substance abuse needs were the most challenging and had the least participation. A general comment was made that "*most of us are in here for drug offenses*" and there was discussion of depression, feelings of anxiety, and inadequacies of treatment approaches: "*I went*

to a 52-week anger management program, for DV, all they talked about was Red Flags and how to deal with being angry. No one ever asked why I was angry". Inmates were more comfortable talking about the need for drug treatment as opposed to need for mental health services. This topic suffered by being the last one to be discussed and from limited time.

Brainstorm of areas were support is needed, as suggested by the group:

- Money/jobs
- Resources/basis needs
- Support/Family
- Shelter/housing
- Transportation
- Counseling/mental health
- Drug treatment
- Education

Strategies and Suggested Actionable Solutions

Strategy	Suggested Actionable Solutions
1. Provide services that support transition prior to release or immediately upon release	• *Provide education on types of employment that are open to ex-offenders* • *Provide information on housing programs, shelters and resources.* • *Provide clear guidelines and education on what constitutes a parole violation with regards to shared housing or shelter (they were confused about this).* • *Make sure the first 72 hours are covered – this is make or break time for many people, don't let people leave without a plan of where they are spending their first few nights especially if they have behavioral health needs.* • *Provide a place or person that they can go to for support and help (care coordination) upon release. Preferably a peer, someone with lived experience.* • *If on medication, connect them to a clinic (they are released with 10-day supply of meds, it is hard to get an appointment within that timeframe).* • *Provide more than 1 bus token. One token gets them to one place, in the first week they need to travel all over, to get medication, housing, etc. If they travel without a ticket it is a parole violation and they can be sent back inside.*
2. Help ex-offenders re-enter the job market	• *Create ways for potential employers to come face to face with ex-offenders – inmates feel that online applications are a waste of time.* • *Ensure that employers understand tax breaks available for hiring ex-offenders.* • *Subsidize cost of training programs (one attendee got into an occupational training course but couldn't afford the $80 materials fee).* • *Set up employment training programs or temporary job opportunities that are just for ex-offenders, help them learn useful skills and prove themselves.*
3. Advocate for system change that can reduce homelessness among ex-offenders	• *Create housing solutions for different people – halfway houses are not open to all populations (i.e. only for those released from State penitentiary), shelters often full, families cannot afford to accommodate them, cannot afford market rent.* • *Establish a protocol that would allow parole or probation officers to make exceptions to the rules that parolees/probationers cannot associate with other parolees/probationers. Inmates understand why there are restrictions but think there needs to be some flexibility – especially given the housing situation. For example, they may know someone who is living with family or have their own place, who might rent a room or provide accommodation for a few nights but can't do this because it would risk (i.e. violate their own parole).*

4. Provide access to drug treatment programs	• *Provide greater access to AOD treatment, both in jail and upon release, and more than just self-help programs.* • *Don't make drug treatment a punishment. Make it available to inmates who want it (a privilege and a choice). Don't waste it on people who don't want it.*

APPENDIX I. SOUTHEASTERN COMMUNITY CONVERSATION REPORT

Overview. Attendees at this community conversation were residents and/or individuals who are providing community based services within Southeastern San Diego (n=11) plus representatives from County Behavioral Health Services (n=4). This special focus group was held at the CARE Center on 10-22-2016. Community outreach was conducted by members of the Live Well Communities Task Force.

Process. A guided conversation structured around four key questions:

1. What would it be good for people to know about Southeastern San Diego to truly help children and families who are dealing with behavioral health issues?
2. What is currently working for families and children who live in Southeastern San Diego around behavioral health?
3. What are the most pressing needs of the Southeastern San Diego community when it comes to children's behavioral health?
4. What ideas or suggestions do you have of approaches or practices that could make the best and biggest difference in improving behavioral health outcomes for children in Southeastern San Diego?

General Themes. The conversation surfaced themes around needs to: a) build trust with this community; b) identify and address discrimination and institutional racism; c) provide services that deal effectively with the impact of trauma and victimization; d) ensure that services are culturally competent; e) create opportunity for enhanced connections and collaborations – especially for new or smaller organizations; f) meet the needs of underserved populations which include youth, refugees, and parents of children with behavioral health concerns.

Findings. Things to be considered and acknowledged when working with Southeastern community:

1. **Impact of Adverse Childhood Experiences and Trauma.** There are factors that impact the behavioral health of residents and contribute to adverse childhood experiences, including: systemic and ongoing racial discrimination; intergenerational history of struggles, substance abuse, incarceration; poverty; lack of educational or employment opportunity for families; homelessness or housing insecurity. There is a perception that institutional neglect and well-intentioned (but misguided) public policies have contributed to struggles both for the community and within individual families.
2. **Barriers to Access.** Barriers to addressing mental health needs include: stigma associated with mental illness; lack of trust of mainstream providers; prevalence of other needs such as shelter, food insecurity, and fears for safety; transportation.
3. **Community Strengths.** The Southeastern community has many strengths and assets that too often get overlooked: rich diversity; family values; faith-based and smaller grassroots organizations doing great work. There are existing efforts that are working that can be built upon and points of entry into the community such as schools, clinics, non-profit organizations. There is a prevailing sense that the Southeastern community is poorly represented (i.e. within the media and among systems), youth especially are misunderstood, and unfairly judged.

4. **One-size fits all approach won't work.** There are shifting demographics within Southeastern community, influx of newcomers including immigrants and refugees. Different cultural communities have different understandings of behavioral health.
5. **Desire for Connection, Respect and Responsibility.** This community would welcome opportunities for greater engagement with County BHS with the following requests: don't over promise; don't just listen – hear; make room for youth and new leaders to be part of the conversation. There is also a willingness for a "call to action" within the community, requesting individuals to step up and be part of the solution.

Summary of promising practices:

- Restorative justice
- Trauma informed care
- Culturally competent parenting programs
- Peer navigators and/or cultural brokers
- Mental health first aid
- Stigma reduction
- Home-based services
- Rapid response with warm-hand off
- Wraparound

Strategies and Suggested Actionable Solutions

Strategy	Suggested Actionable Solutions
1. Create a working framework for real change	• *Continue to have dialogue with this community and find ways to connect with different sectors and groups.* • *Include innovative approaches that break down stigma, build resiliency and address trauma – look at the It's Up to Us Campaign.* • *Provide ongoing training on trauma and ACE – not one-time efforts.* • *Use "Big Data" to inform changes.* • *Plan for an integrated and coordinated approach to BHS (mental health and substance use.)* • *Provide a way for smaller and emerging non-profit organizations to be able to provide county funded services. Encourage larger nonprofits to partner with smaller ones.* • *Address issues of misdiagnosis (PTSD not ADHD) and "Hood Disease".* • *Make room for research-based approaches not just evidence-based.*
2. Utilize a strength-based approach that builds upon existing community assets	• *Involve young people in decision making and planning and build on youth leadership.* • *Use points of entry that are already in place – schools (Lincoln and King Chavez), family resource centers, community-based clinics and health centers, grassroots and home-based providers.* • *Understand the value of faith-based leaders (example of United Women of Africa using faith leaders to address intergenerational divide).* • *Recognize the importance of family unity.*
3. Provide accessible youth-friendly services	• *Embed life skills, restorative justice opportunities, mentoring and other services in schools. Occupy space in schools to make services visible.* • *Talk about youth issues (suicide, drugs) and use language like wellness and student services (not mental health and treatment or counseling).* • *Provide services for out of school youth as part of CSOC.* • *Support on campus suspensions – keep youth in school.* • *Work with school based Family Resource Centers.*

4. Support parents and grandparents	• *Supplement parenting skills in a culturally competent way.* • *Support or expand existing prevention and early intervention programs and services that are working* • *Provide care-coordination and support in navigating services – use peer workers or cultural brokers. Use a "warm hand-off" approach not just paper referrals.* • *Provide services for very young children, include a focus on early childhood education in training programs.*

APPENDIX J. FEMALE INMATES FOCUS GROUP REPORT

Overview. This focus group was conducted with a group of six female inmates who reside in fair housing facilities within the Las Colinas Detention and Reentry Facility (LCDRF). The group was diverse with three individuals who identified as Hispanic, one as African American, one as White and one as Middle Eastern. This facility serves as the primary point of intake for women offenders in San Diego County and is operated by the County of San Diego Sherriff's Department. It is a 'heavily programmed' facility offering many drug and alcohol intervention and job training programs and the InReach transition program. Most but not all of attendees were repeat offenders and several has been in the facility for over 12 months.

Process. A structured but conversational format was used, using the following agenda:

1. Overview of meeting purpose - to gather information about what is needed to support successfully re-entry into community.
2. Discussion about specifically what types of services are needed, where the gaps and challenges are, and their ideas for how these gaps and challenges could be addressed, also on how Los Colinas programs were helping them to not return to detention.
3. Closing consisted of some troubleshooting with the counselor around some of the issues that were raised for individual inmates

General Themes. Attendees provided insight into some of the barriers and challenges to reentry. Due to LCDRF's focus on reentry, and the fact that the women present were engaged in a number of in-jail rehabilitative services, much of the conversation focused upon how the facilities' programs were supportive of re-entry and what could be done to make them even better.

Findings. The following are general reflections and highlights from the discussion.

1. **There are numerous services and programs available at this facility which set the women up for success upon release.** services on site include AOD programs, vocational and general education, self-improvement and wellness services including mental health providers. Some inmates qualify for supervised re-entry and early release services that includes monitored supervision. There is general appreciation for the quality of services and support and recognition that they are making a difference. Participants who had had the chance to take advantage of Los Colinas programs felt that their lives were changed in a very positive way; several specifically stated said they would have never been able to change without the program.
2. **There is room to enhance pre-release re-entry/rehabilitative services.** While there was consensus among the participants that this facility is superior to others (i.e. has a lot more services and supports) there is still room for improvement in areas such as early assessment, earlier access to programs, cultural competency, and ability to tailor services to individual needs. The women made a strong connection between availability and quality of pre-release services and their ability to succeed in the community and avoid re-entry.
3. **Pre and Post-release care coordination and support is seen as a priority need.** Inmates recognize that in order to succeed upon release they need a) help establishing a plan and for this to start as soon as possible (i.e. allow InReach to begin sooner by increasing InReach staff); b) once released they need ongoing assistance accessing and navigating needed services including AOD treatment

and counseling; c) want continued opportunity for peer support either one-on-one or via groups provided by community agencies once they are released.

4. **Other re-entry needs focused upon wellness and self-sufficiency.** Gaps in community services were those that meet the needs of women who are not eligible for transitional living or treatment but who still need ongoing support in order to sustain the gains they made while in jail.

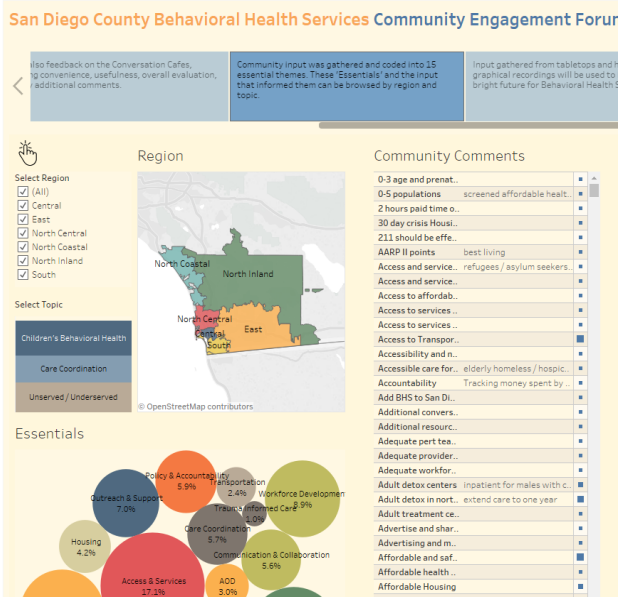
Strategies and Suggested Actionable Solutions

Strategy	Suggested Actionable Solutions
Provide community services that address barriers and challenges to reentry and reduce risk for recidivism	• *Offer diverse types of Residential Drug Treatment Programs upon release* • *Offer support for job placement and additional job training* • *Provide job training that leads to jobs that pay more than minimum wage* • *Provide transitional housing and re-entry support for inmates not needing rehab* • *Several participants had mandated supervision upon their release, which was seen as a benefit that provided ongoing services and a place in a sober living facility; one participant did not have this or parole, and felt that after all the services provided in jail she might have trouble and reoffend without support* • *Participants who did not fit into either a sober living home or Monitored Supervision clearly felt they were at risk of reoffending – suggest that community-based case management, care coordination services are needed* • *Provide access to peer-led support groups focused upon helping women sustain motivation and encourage each other's success once they are released.*
Provide support with the transition from jail to community	• *Provide care coordination services - "Not knowing where I can get services when I leave makes me contact people I should not hang out with"* • *Assure quality of medication transition for inmates (warm hand-off between providers)*
Increase or improve facility programs that contribute to transition success	• *Provide InReach services upon entry and ongoing rather than just prior to release; Project InReach was cited as very successful, and all wanted to participate in it, but due to demand the program services were only offered when clients were nearing release and many felt this was too late; all participants mentioned the need to expand this program and to continue it beyond release* • *Reduce paperwork burden for inmates to apply for programs while in Los Colinas that would serve to support reentry*

APPENDIX K. INTERACTIVE DATA STORY AND FORUM GRAPHIC RECORDING

Graphic Recording of the Aggregated Community Conversations

Interactive Data Results



Appendix I

Innovation Evaluation and Proposals – Cycle 3

COUNTY OF SAN DIEGO – HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES

Mental Health Services Act Innovation Projects (Cycle 3)

Annual Report: Year 1

FY 2015-16

TABLE OF CONTENTS

CAREGIVER WELLNESS PROGRAM (INNOVATIONS-11)

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

ANNUAL REPORT: YEAR 1 (7/1/15 - 6/30/16)

The Caregiver Wellness Program (CWP) is funded through the Innovations (INN) component of the Mental Health Services Act. CWP is designed to provide screening, needs assessments, linkage to services and resources, as well as therapeutic, educational, and support groups for parents and caregivers of children receiving services through KidSTART, a comprehensive program for children ages 0-5 with multiple and complex socio-emotional, behavioral health, and developmental needs. CWP is intended to complement KidSTART services by directly addressing caregiver needs while their child is in treatment. Both CWP and KidSTART services are provided through Rady Children's Hospital Chadwick Center for Children and Families.

A primary innovation of CWP is the addition of Parent Care Coordinators (PCC) to the treatment team. After completing a detailed family needs assessments, the PCCs provides emotional support and worked to link caregivers with appropriate services and resources including their own behavioral health care. Additionally, therapeutic, educational, and support groups are offered directly through CWP in multiple San Diego County locations. CWP services are expected to improve the wellbeing of caregivers so that they could better care for themselves and their child/children.

EXECUTIVE SUMMARY

The Caregiver Wellness Program (CWP; INN-11) is designed to support parents/caregivers of children receiving treatment services through the County of San Diego KidSTART program by assessing caregivers and then linking to needed mental health, alcohol and drug, or other services, as well as directly providing therapeutic, educational, and support groups. A Parent Care Coordinator (PCC) role was created to provide caregivers with individualized case management following the completion of a detailed in-home family needs assessment.

- During Fiscal Year 2015-16, 82 caregivers were screened and 24 entered the CWP. Caregivers received a total of 99 case management visits and 91 psychoeducation support group sessions as of 6/30/2016.
- The primary language for 29.2% of caregivers was Spanish, with 58.3% indicating being of Hispanic origin. Half of the caregivers (50.0%) had a high school education or less.
- In general, caregivers who entered into CWP expressed favorable attitudes about the benefits of and their needs for receiving behavioral health services.
- The in-home needs assessments highlighted a wide range of caregiver needs. About half of respondents indicated a need for more knowledge parenting their children (61.9%), more emotional support (57.1%) and meeting with a professional to discuss problems (47.6%). Other common need areas were related to housing (38.1%), financial resources (33.3%), education (33.3%) and legal matters (28.6%).
- Over half of the caregivers (52.4%) were concerned that other demands on time (e.g., participating in services for their child) would make it difficult to participate in CWP.
- Based on the limited follow-up data (n=7) available as of 6/30/2016, all caregivers were satisfied with the services received through CWP and indicated receiving a range of emotional, educational, and tangible supports from PCCs.
- Caregiver participation rates in the CWP psychoeducation support groups were similar (about 50%) regardless of whether caregivers were accessing other non-CWP behavioral health services.
- CWP staff identified key factors that helped achieve CWP program goals: 1) providing one-on-one, in-home needs assessments, 2) offering psychoeducation groups within CWP, 3) having a structured curriculum for these groups, 4) making PCCs region-specific for building local resource expertise, 5) collaboration and communication between CWP leadership, PCCs, and therapists, and 6) CWP staff "buy-in" into the importance of caregiver well-being to child care.

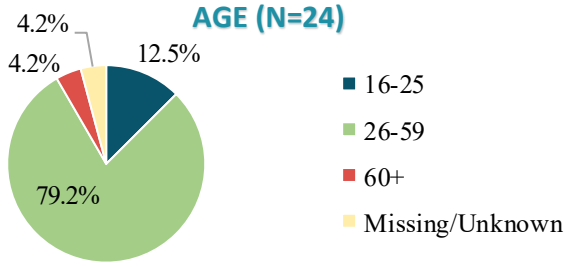
RECOMMENDATIONS

Primary recommendations include: 1) simplify and shorten the screening/assessment process, 2) accelerate timeframe for development of caregiver wellness plan and provision of PCC coordination and support services after in-home assessment, 3) explore providing individual therapy as part of CWP, 4) enhance the program's capacity to address barriers to CWP participation, 5) identify more bilingual therapists in the community that CWP can refer to, 6) provide additional PCC trainings, and 7) facilitate regular communication and coordination between PCCs and therapists.

CAREGIVER WELLNESS PROGRAM PARTICIPANT DEMOGRAPHICS

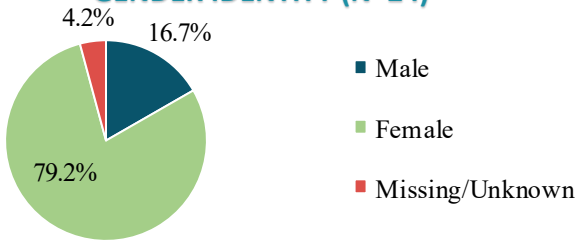
The following demographic data were collected from a participant self-report survey administered at the start of the CWP program.

AGE (N=24)



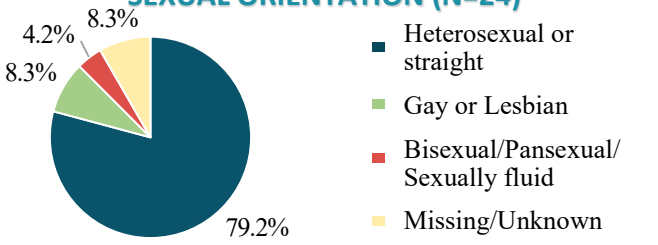
The majority of participants (79%) were between the ages of 26 and 59.

GENDER IDENTITY (N=24)



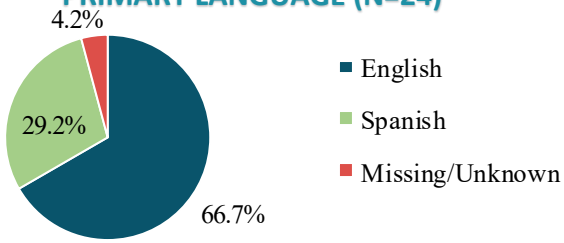
About three-quarters of participants were female (79%), and 17% of participants were male.

SEXUAL ORIENTATION (N=24)



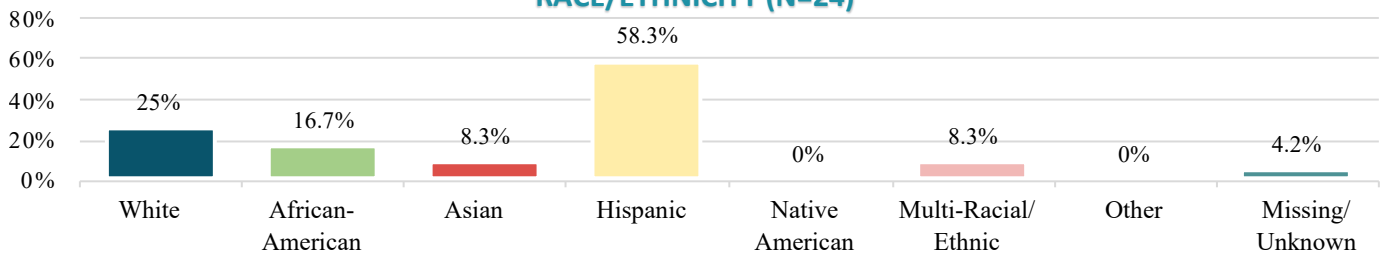
Most (79%) participants were heterosexual or straight, and about 8% indicated being gay or lesbian.

PRIMARY LANGUAGE (N=24)



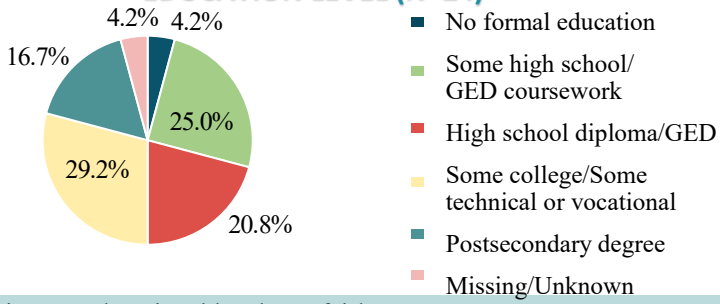
English was the primary language for two-thirds of participants (67%), with Spanish being the primary language for 29% of participants.

RACE/ETHNICITY (N=24)



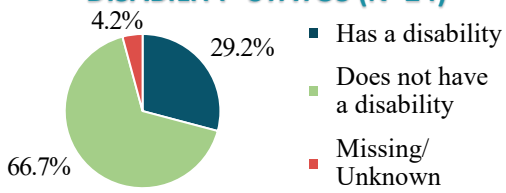
Fifty-eight percent of participants identified themselves as Hispanic, and 41.7% specifically indicated being of Mexican origin. Totals may exceed 100% as caregivers were able to indicate more than one race/ethnicity.

EDUCATION LEVEL (N=24)



Participants' educational level was fairly split between several categories, the largest being some high school/

DISABILITY[1] STATUS (N=24)



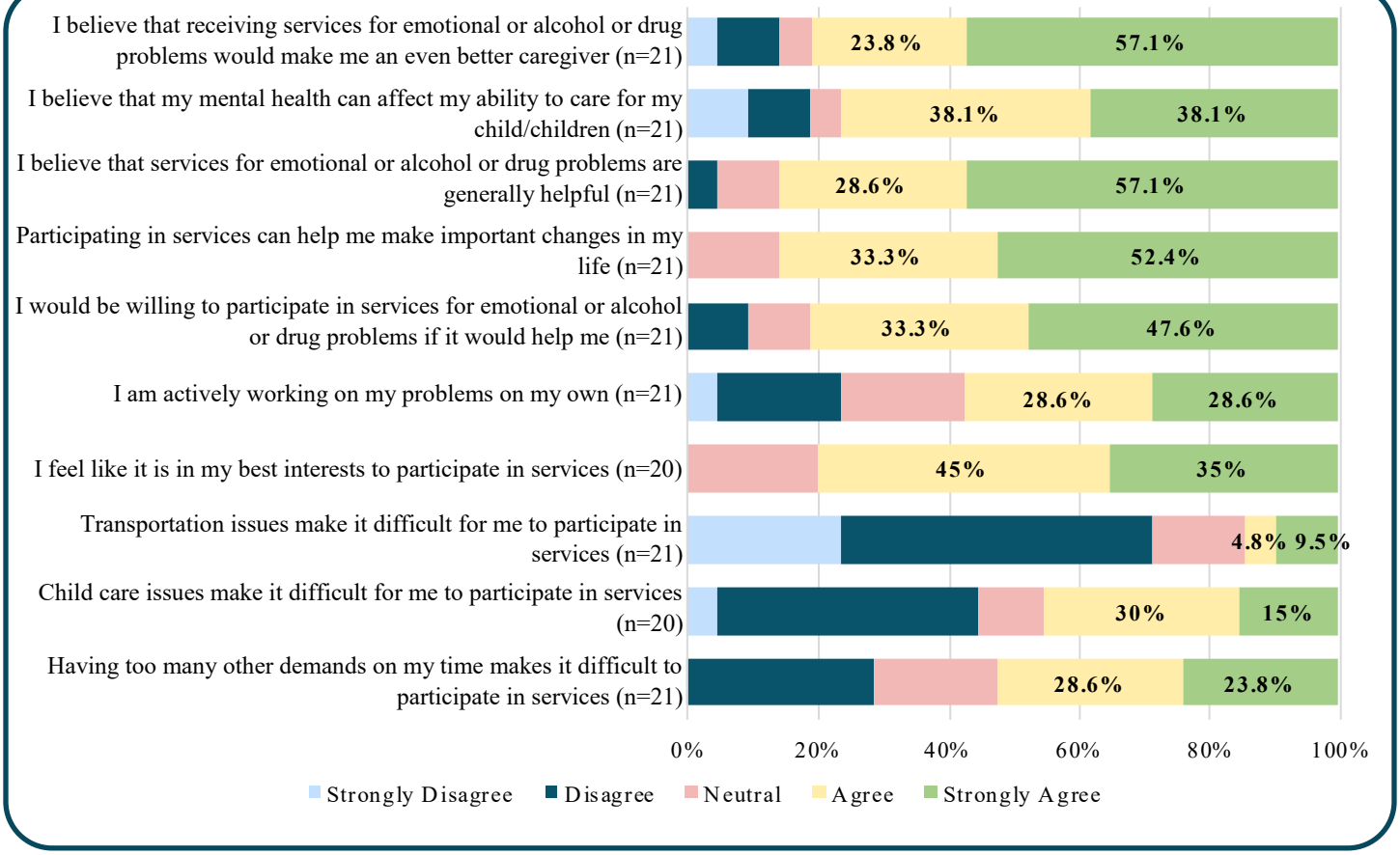
Twenty-nine percent of participants reported having some form of non-SMI disability.

The majority (92%) of participants had never served in the military.

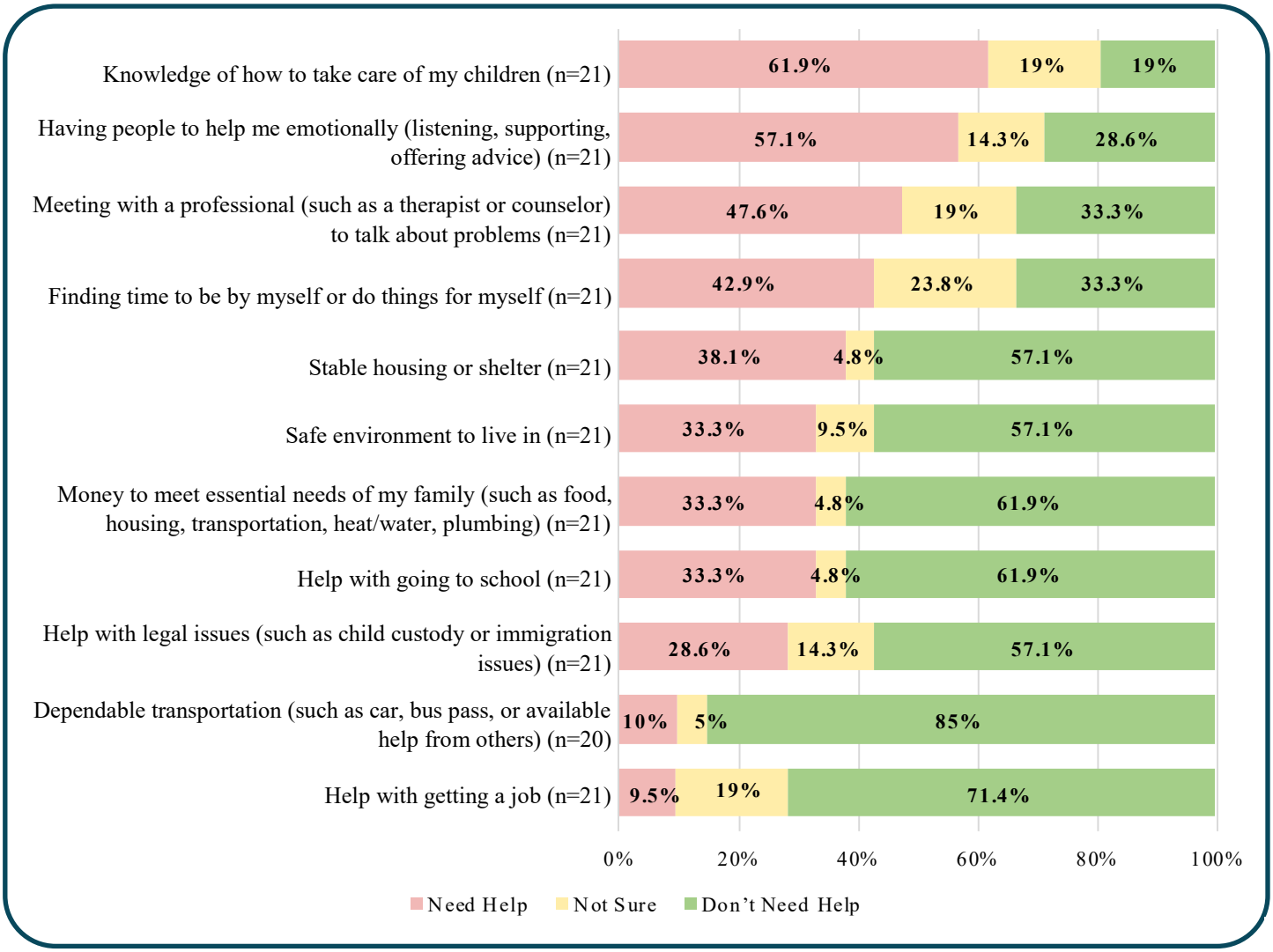
[1] *A disability was defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness (SMI).*

KEY EVALUATION FINDINGS: BASELINE

Upon entering CWP, caregivers typically expressed favorable attitudes about the value of and need for receiving additional support services (see chart below). For example, over 80% agreed or strongly agreed that "receiving services…would make [them] an even better caregiver" (80.9%), that such services were "generally helpful" (85.7%), that they would be "willing to participate in services" (80.9%), and that it is in their "best interest to participate in services" (80.0%). Relatively few (14.3%) thought that transportation issues would make it difficult to participate in services, but concerns about childcare or other demands on their time were more prevalent (45.0% and 52.4%, respectively).

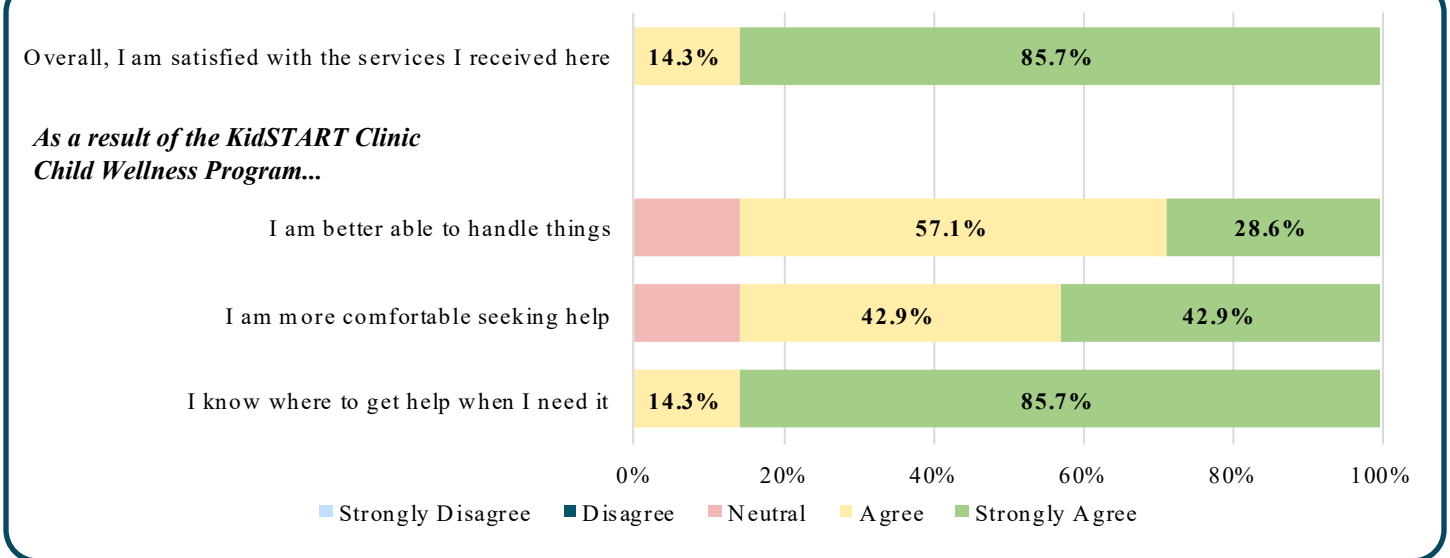


Select items from the comprehensive baseline family needs assessment are listed in the chart on the next page. Consistent with the caregiver's openness and interest in receiving mental health and/or alcohol and drug services discussed previously, almost half of caregivers indicated on a baseline family needs assessment that they needed help "meeting with a professional…to talk about problems" (47.6%), and over half (57.1%) indicated needing assistance with finding "people to help [them] emotionally." Additionally, the majority (61.9%) wanted help increasing their "knowledge of how to take care of [their] children." Needing help with other issues such as housing, finances, education, and legal matters were each expressed by about one-third of all caregivers entering CWP.

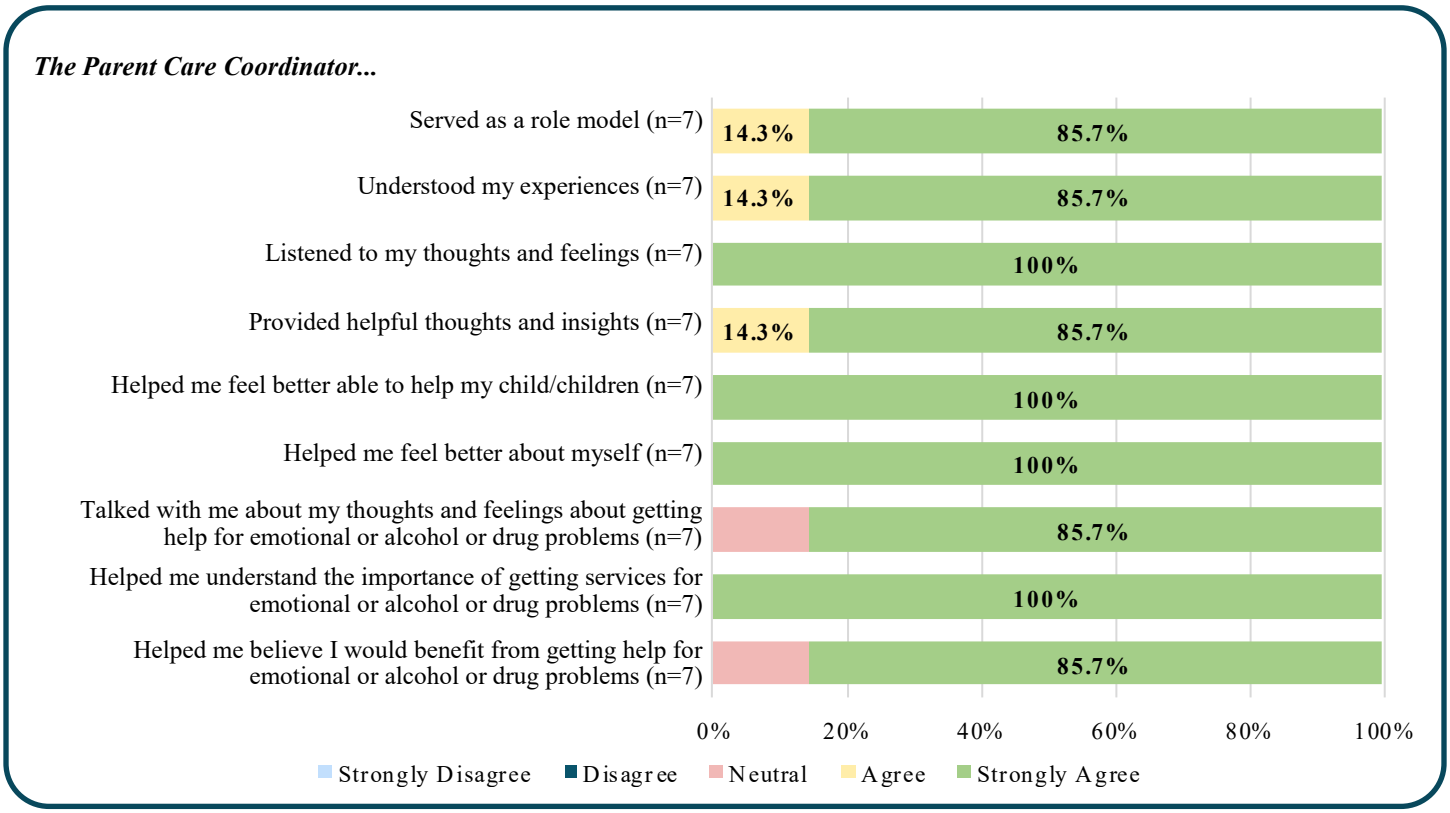


KEY EVALUATION FINDINGS: FOLLOW-UP

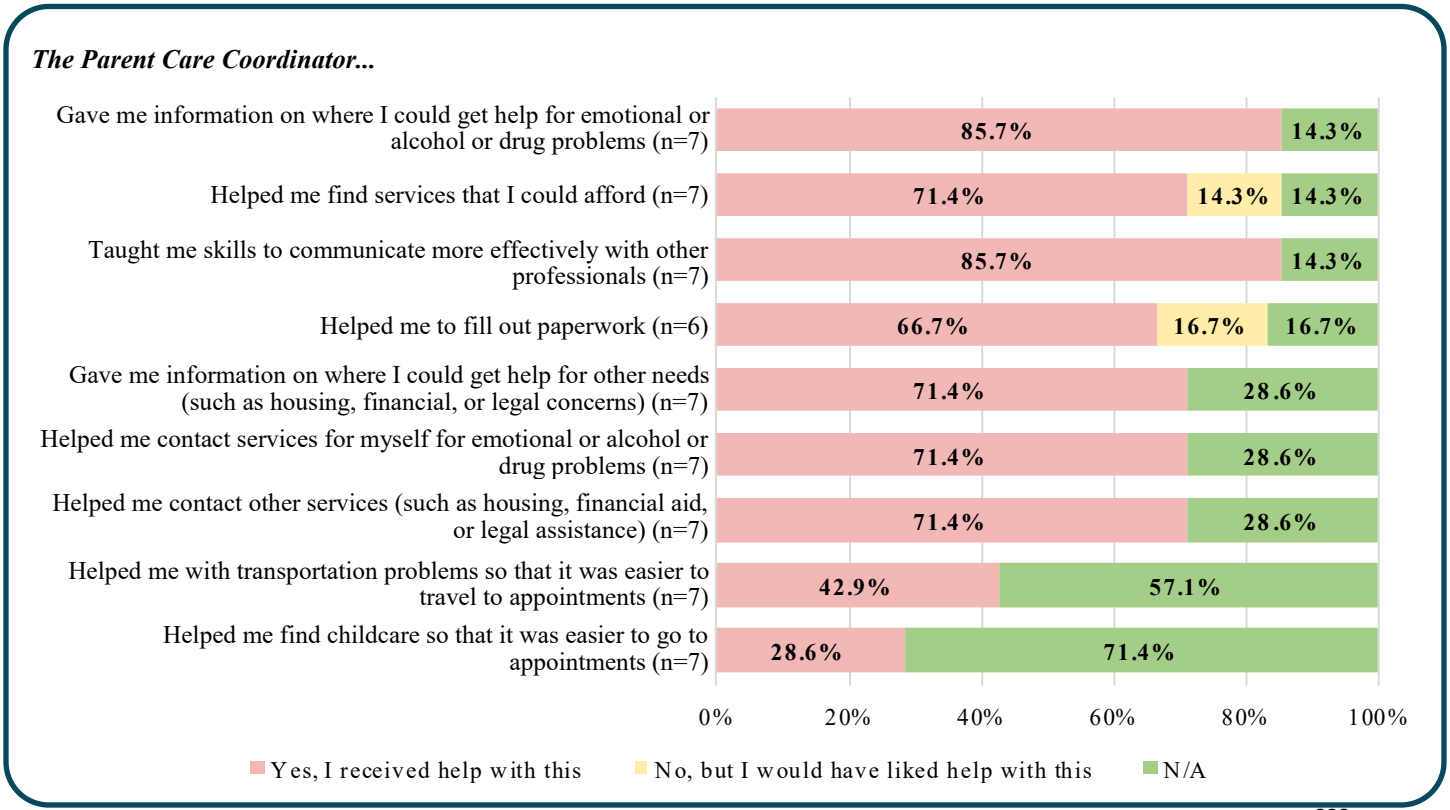
As seen in the chart below, all caregivers with follow-up data (n=7) indicated they were satisfied with the CWP services received (85.7% strongly agreed that they were satisfied with services). While respondents almost universally agreed or strongly agreed with being "better able handle things", "more comfortable seeking help" and "know[ing] where to get help" as a result of their participation in CWP, it appeared that knowledge of where to get help when needed was a primary outcome for caregivers (85.7% strongly agreed with this item).



The chart below shows that caregivers with follow-up data nearly universally "strongly agreed" that their PCC provided a range of emotional and educational supports, including "listening to [their] thoughts and feelings", helping them "understand the importance of getting services for emotional or alcohol or drug problems", and helping them "feel better able to help [their] child/children".



Additionally, Parent Care Coordinators provided a range of specific services to those who needed them, such as giving caregivers information about where to get help, teaching about effective communication, assisting with paperwork, and empowering caregivers to contact other needed support services (see chart below). Most caregivers with follow-up data indicated that they did not need assistance with finding transportation or childcare to attend appointments (57.1% and 71.4%, respectively). For those who did need these types of more tangible assistance, caregivers indicated that they did receive help from Parent Care Coordinators in these areas.



UTILIZATION OF SERVICES AT START OF THE CAREGIVER WELLNESS PROGRAM

As shown in Table 1, approximately one-quarter (23.8%) of caregivers indicated they had some type of hospitalization or residential treatment for mental health or substance abuse issues in the 90 days prior to entering CWP. At the start of CWP, 57.1% of caregivers were receiving or waitlisted for psychological counseling, and one person (4.8% of caregivers) was attending or waitlisted for alcohol or drug services. One-third (33.3%) of caregivers were using prescription medication for their emotional or mental health needs. Data from the County of San Diego Behavioral Health Services indicated that in the 90 days prior to starting CWP, three (3; 12.5%) of these caregivers had received outpatient treatment services through a County-funded program.

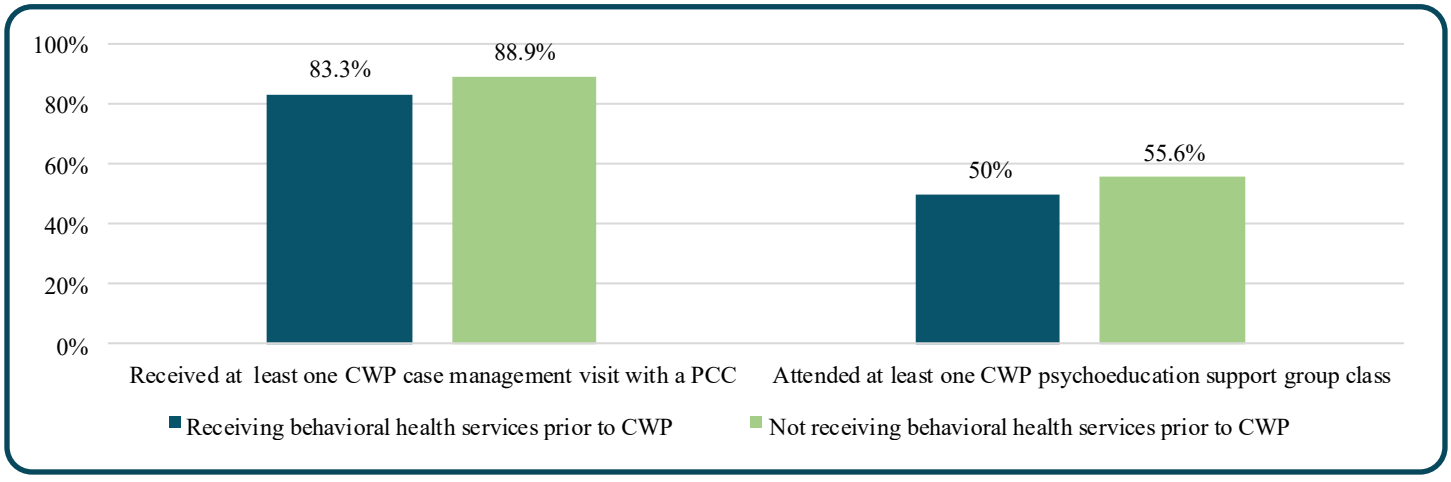
TABLE 1. CAREGIVER BEHAVIORAL HEALTH SERVICE UTILIZATION AT START OF CAREGIVER WELLNESS PROGRAM

	n	Yes	No
In the past 90 days have you been admitted for an overnight stay in a hospital or other facility to receive help for problems with your emotions, nerves, mental health, or your use of alcohol or drugs?	21	5 (23.8)%	16 (76.2%)
Are you currently receiving or are you on a waitlist for psychological counseling or therapy for emotional problems with any type of professional?	21	12 (57.1%)	9 (42.9%)
Are you currently going to or are you on a waitlist for a clinic or doctor for an alcohol or drug problem?	21	1 (4.8%)	20 (95.2%)
Are you currently using a prescription medicine for your emotions, nerves or mental health from any type of professional?	21	7 (33.3%)	14 (66.7%)

UTILIZATION OF CAREGIVER WELLNESS PROGRAM SERVICES

Through 6/30/2016, the CWP staff had provided 99 case management sessions and 91 psychoeducational support group sessions to the 24 persons participating in CWP. Of these 24 caregivers, 75% had received at least one case management visit (average of 5.5 visits) and 45.8% had participated in at least one psychoeducational support group session (average of 8.3 group sessions).

The chart below presents a comparison of the CWP service utilization of patterns based on whether a caregiver reported they were receiving some form of mental health or substance abuse counseling or assistance at the time they started CWP. The findings indicated that there were essentially no differences between the types of CWP services accessed by caregivers that were involved in other services and by caregivers that were not. About 85% of both groups of caregivers received at least one case management visit, and about 50% of both groups participated in the psychoeducational support groups.



These findings suggest that CWP had expanded access to and successfully engaged both caregivers who were not previously receiving behavioral health services, as well as supplementing the services for those who were already receiving some other forms of mental health or substance abuse treatment.

An examination of County of San Diego Behavioral Health Services data for the subset of caregivers who had started CWP at least 90 days before 6/30/2016 (the end of Year 1), indicated that there were no new caregivers linked up to County-funded outpatient treatment services. However, the persons receiving behavioral health services before starting CWP continued to do so after starting CWP. No SDCBHS psychiatric hospitalizations, emergency psychiatric unit visits or psychiatric emergency response team visits occurred in the 90 days before or after caregivers started CWP. These service utilization patterns will continue to be monitored in future reporting periods as more caregivers receive CWP services.

CAREGIVER WELLNESS PROGRAM ANNUAL STAFF FEEDBACK SURVEY

At the end of the first year of providing the INN Caregiver Wellness Program, administrative and provider staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the Caregiver Wellness Program. There were 12 respondents from the 15 persons invited to participate in the survey, a response rate of 80%. For the open-ended survey questions, at least two evaluators reviewed and coded the responses, and any discrepancies were discussed to arrive at a consensus on the key response themes.

1. *Factors that helped achieve CWP program goals:*
   a. Providing one-on-one, in-home comprehensive needs assessments
   b. CWP staff "buy-in" to importance of caregiver wellbeing for improving child behaviors
   c. Structured curriculum for psycho-education support groups
   d. Collaboration and communication between program leadership, PCCs and therapists
   e. Offering therapeutic, education, and support groups to caregivers not interested in individual mental health treatment
   f. Region specific PCCs developed expertise in available resources in that area
2. *Factors that inhibited achieving CWP program goals*:
   a. Lengthy/complicated assessment process can delay or prevent getting a caregiver connected with a PCC
   b. Not able to identify the caregivers that are in more need of services through the screening tool
   c. Not able to provide individual psychotherapy directly through CWP to caregivers
   d. Caregivers beliefs that it is more important to obtain services for their child than for themselves
   e. Time, transportation, and other tangible barriers to caregiver participation in services
3. *Factors that facilitated caregiver participation in CWP services:*
   a. Timely engagement with PCCs following needs assessment
   b. Regular, consistent contact with PCCs
   c. Flexibility to offer groups at wide range of times and days
   d. Clear communication to caregivers about how CWP services will help them and their child
   e. Effectively connecting caregivers with other needed resources or services
   f. Providing caregivers with information and tools that they perceive as important
   g. Being client-centered, respectful, and responsive, to build caregiver rapport and trust
4. *Caregiver responses to recommendation to participate in CWP:*
   a. Some very open and interested, others ambivalent or hesitant
   b. Often more interested in CWP and behavioral health services after the in-home needs assessment
   c. Knew and agreed with recommendation for behavioral health care, but prioritized their child's needs over their own needs
   d. Concern about how to care for themselves given other time commitments, particularly to their child
5. *Primary caregiver benefits of psychoeducation support group participation:*
   a. Increased understanding of the importance of caregivers wellness to their child
   b. Empowered caregivers with additional knowledge through psychoeducation
   c. Provided emotional support and comfort in a "safe space"
   d. Created opportunities for "light bulb" moments where caregivers have important realizations about caring for themselves and/or their child
   e. Facilitated the development of peer-support social relationships with others in similar situations
   f. Helped to normalize situation and reduce anxiety by seeing other caregivers with similar challenges
6. *Primary strategies for linking caregivers to external non-CWP services:*
   a. Acknowledging and empathizing with caregiver ambivalence/hesitancy to receive other services
   b. Normalizing the need for services
   c. Building trusting and supportive relationships with caregivers
   d. Making referrals directly for caregivers and following up with caregiver and agency
   e. Finding a good match between caregiver needs and available external services/resources
   f. Prioritizing caregiver goals
   g. Conducting a thorough needs assessment
   h. The existence of the PCC as a dedicated position for facilitating linkages for caregivers

KEY YEAR 1 CAREGIVER WELLNESS PROGRAM "LEARNINGS"

1. Providing a comprehensive in-home needs assessment was crucial for obtaining a thorough understanding of the range of potential caregiver needs and often facilitated rapport building and caregiver "buy-in" to CWP.
2. Prompt development of the caregiver wellness plan and provision of PCC coordination and support services after completing the needs assessment was important for retaining and promoting caregiver CWP participation.
3. The PCC role facilitated both emotional support and education of caregivers, as well as identifying and connecting with needed external resources and services.
4. Offering therapeutic, educational and support groups directly within the CWP was an effective strategy for providing needed and desired caregiver-focused behavioral health services.
5. Caregiver participation rates in the groups provided within CWP were similar (about 50%) regardless of whether caregivers were also receiving other behavioral health services. This indicated that the groups were capable of both expanding access to needed information for those without any other behavioral health supports as well as supplementing any existing behavioral health care.
6. Need to ensure identification of all caregivers who may benefit from CWP services without creating too lengthy or cumbersome screening and assessment process.
7. Spanish-speaking PCCs and therapists were vital to delivering CWP services. Need additional Spanish-speaking therapists in the community who can receive adult behavioral health treatment referrals from CWP.
8. The many other child-related meetings and treatment sessions caregivers had to attend as well as other commitments of daily life substantially limited the time that caregivers were available to participant in services directed toward there own wellbeing.
9. Group sessions and PCC support increased caregiver awareness of the importance of receiving their own services to promote their wellness and the well-being of their children.
10. CWP participation enhanced KidSTART therapists' knowledge of caregiver strengths and needs, which facilitated caregiver engagement in child-caregiver dyadic treatment services and informed child treatment strategies.

YEAR 1 PROGRAM CHANGES

There were no changes to the INN-11 Caregiver Wellness Program during the first year of service provision (7/1/2015 to 6/30/2016) that differed substantially from the initial design of the program. As is typical during program start-ups, some basic practices and procedures were adjusted over the course of the first year to better fit the emerging service delivery context. These modifications included minor changes to the caregiver screening/assessment process, refinement of psychoeducation support group curriculum, PCC roles and responsibilities, and communication between CWP staff. However, no fundamental program changes were made.

Review of program services was integrated into the on-going operations of CWP, and during the latter part of Year 1, leadership began an assessment of practices and procedures through review of program data and informal feedback as well as input obtained during "debriefing meetings" with staff. Elimination of the screening process, better integration of the caregiver assessment into the case flow, assignment of a PCC concurrent with assignment of the child's therapist, and enhanced training for PCCs were keys areas that were identified for program changes in Year 2.

YEAR 1 PROGRAM RECOMMENDATIONS

Recommendations for how to improve the Caregiver Wellness Program during Year 2 and further increase caregiver access to needed behavioral health and other support services and resources include the following:

1. Simplify and shorten screening/assessment process.
2. Following the completion of the in-home assessment by the PCC, accelerate timeframe for development of caregiver wellness plan and provision of PCC coordination and support services.
3. Explore potential for providing individual therapy as part of CWP.
4. Address barriers to CWP participation (e.g., improve caregiver outreach and engagement strategies, incentivize attendance at group sessions, offer classes at convenient times and locations, provide additional transportation and child care, etc.).
5. Identify more bilingual and/or Spanish language therapists in the community who can receive adult behavioral health treatment s referrals from CWP.
6. Provide additional training and education opportunities for PCCs (e.g., engagement strategies, trauma-informed care, etc.).
7. Create additional opportunities for communication and coordination between PCCs and therapists.

For additional information about the INN–11 Caregiver Wellness Program and/or this annual report, please contact:
David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

Participant Demographics: INN 11 Caregiver Wellness Program

Supplemental Summary

Age	**N**	**%**
0-15 (children/youth)	0	*0%*
16-25 (transition age youth)	3	*12.5%*
26-59 (adult)	19	*79.2%*
60+ (older adults)	1	*4.2%*
Unknown/preferred not to answer	1	*4.2%*
Missing/did not answer	0	*0%*
TOTAL	**24**	***100%***

Race	N	%
Black/African American	4	*16.7%*
Asian	2	*8.3%*
White	6	*25.0%*
Native American	0	*0%*
More than one race	1	*4.2%*
Other	0	*0%*
Unknown/preferred not to answer	1	*4.2%*
Missing/did not answer	10	*41.7%*
TOTAL	**24**	***100%***

Ethnicity	**N**	**%**	**N**	**%***
Hispanic or Latino	13	*54.1%*		
Mexican			10	*41.7%*
Puerto Rican			1	*4.2%*
Other			1	*4.2%*
Missing/did not answer			1	*4.2%*
Non-Hispanic or Non-Latino	9	*37.5%*		
Filipino			1	*4.2%*
Japanese			1	*4.2%*
Other			0	*0%*
Missing/did not answer			7	*29.2%*
More than one ethnicity	1	*4.2%*	1	*4.2%*
Unknown/preferred not to answer	1	*4.2%*	1	*4.2%*
Missing/did not answer	0	*0%*	0	*0%*
TOTAL	**24**	***100%***		

* Totals may add to more than 100% since participants could indicate multiple subethnicities.

Primary Language	N	%
English	16	*66.7%*
Spanish	7	*29.2%*
Unknown/preferred not to answer	1	*4.2%*
Missing/did not answer	0	*0%*
TOTAL	**24**	***100%***

Sexual Orientation	N	%
Gay or Lesbian	2	8.3%
Heterosexual or Straight	19	79.2%
Bisexual	1	4.2%
Unknown/preferred not to answer	2	8.3%
Missing/did not answer	0	0%
TOTAL	**24**	**100%**

Disability	N	%	N	%*	N	%*
Yes disability	7	*29.1%*				
Communication disability			4	*16.7%*		
Difficulty seeing					4	*16.7%*
Mental disability			3	*12.5%*		
Learning disability					3	*12.5%*
Physical/mobility disability			0	*0%*	0	*0%*
Chronic health condition			2	*8.3%*	2	*8.3%*
Other disability			0	*0%*	0	*0%*
No disability	16	*66.7%*	16	*66.7%*	16	*66.7%*
Unknown/preferred not to answer	1	*4.2%*	1	*4.2%*	1	*4.2%*
Missing/did not answer	0	*0%*	0	*0%*	0	*0%*
TOTAL	**24**	***100%***				

* Totals may add to more than 100% since participants could indicate multiple disabilities.

Veteran Status	N	%
Yes	2	*8.3%*
No	21	*87.5%*
Unknown/preferred not to answer	1	*4.2%*
Missing/did not answer	0	*0%*
TOTAL	**24**	***100%***

Gender: Assigned Sex at Birth	N	%
Male	4	*16.7%*
Female	19	*79.2%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	1	*4.2%*
TOTAL	**24**	***100%***

Gender: Current Gender Identity	N	%
Male	4	*16.7%*
Female	19	*79.2%*
Unknown/preferred not to answer	1	*4.2%*
Missing/did not answer	0	*0%*
TOTAL	**24**	***100%***

FAMILY THERAPY PARTICIPATION ENGAGEMENT (INNOVATIONS-12)

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

ANNUAL REPORT: YEAR 1 (7/1/15 - 6/30/16)

The Family Therapy Participation Engagement (FTPE) program is funded through the Innovations (INN) component of the Mental Health Services Act. FTPE is designed to increase parent and caregiver engagement in the treatment of their child through the innovative use of Parent Partners to encourage participation in Family Therapy. Note, we use the term "caregiver" in the remainder of this report to signify either the parent or other caregivers of the child receiving treatment.

Parent Partners are required to have prior experience caring for children receiving behavioral health services to facilitate their role as peer-supports for caregivers in similar situations. Parent Partners are expected to enhance caregivers' understanding of the importance of active involvement in their child's treatment and to encourage caregiver participation in Family Therapy sessions. Parent Partners are intended to offer short-term supports (i.e., typically 2-4 visits, but more if needed), with Motivational Interviewing (MI) techniques providing the guiding framework for how Parent Partners engage with caregivers. Parent Partner staff are integrated into six existing Child, Youth, and Family (CYF) programs operating throughout the County of San Diego.

EXECUTIVE SUMMARY

The Family Therapy Participation Engagement (FTPE; INN-12) program is designed to increase caregiver participation in Family Therapy visits by using peer-support Parent Partners to enhance caregivers' understanding of the importance of active participation in their child's treatment and to encourage participation in Family Therapy sessions.

- During Fiscal Year 2015-16, a total of 2,595 Parent Partner visits were provided to caregivers of 592 children receiving behavioral health treatment services at six agencies throughout San Diego County.
- Based on available caregiver demographics, most FTPE caregiver participants were female, and the majority spoke Spanish as their primary language. Over half of caregivers had a high school or lower level of education, and at least 15% were unemployed and looking for work.
- After implementing FTPE, regular participation in Family Therapy (i.e., at least 1 session per month) increased to 42.0% of children starting treatment services—up from 26.8% before FTPE's implementation (a 57% increase).
- Caregiver visits with Parent Partners appeared to increase the likelihood of regular participation in Family Therapy. About one-third (35.9%) of caregivers with no Parent Partner visits regularly participated in Family Therapy sessions (i.e., at least 1 session per month), compared to 53.2% of those with at least 1 Parent Partner visit. This 48% higher participation rate was accomplished despite Parent Partners appropriately focusing their efforts on caregivers less likely to participate in Family Therapy.
- Caregivers reported very high overall levels of satisfaction with Parent Partner services (97.5% satisfaction). Over 90% agreed or strongly agreed that Parent Partners "understood [their] experiences", "helped [them] understand the importance of Family Therapy", and made them "feel [they] could help [their] child", in addition to providing other forms of support.
- Key factors contributing to increased Family Therapy participation identified by FTPE administrative and service provider staff included: 1) support, encouragement, education, and tangible resources provided to caregivers by Parent Partners; 2) MI training and other trainings received by Parent Partners; 3) Parent Partners' "lived experience" with the CYF Behavioral Health System; and 4) an increased team care approach that facilitated Parent Partner and therapist communication/collaboration.

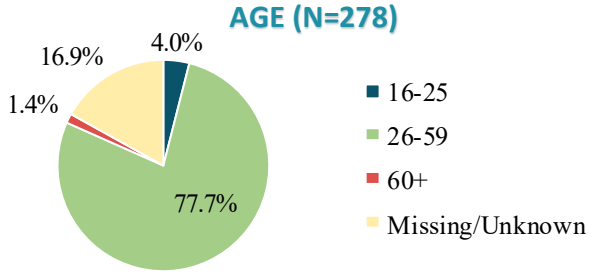
RECOMMENDATIONS

Primary recommendations include: 1) provide additional Motivational Interviewing and other trainings for Parent Partners, 2) increase availability of Parent Partner services (e.g., more FTE), 3) provide more opportunities for group meetings with caregivers and Parent Partners, 4) provide additional resources to address "tangible" barriers to Family Therapy visits (e.g., transportation and child care.), and 5) identify ways to encourage and support Parent Partners to minimize staff turnover and facilitate hiring.

FAMILY THERAPY PARTICIPATION ENGAGEMENT CAREGIVER DEMOGRAPHICS[1]

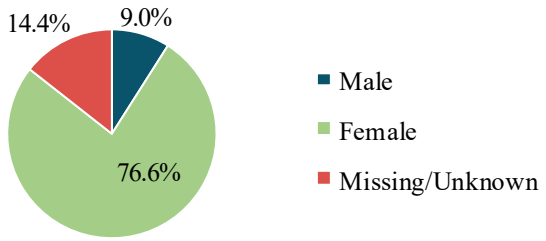
The following demographic data were collected from a caregiver self-report survey administered at the start of the FTPE program.

AGE (N=278)



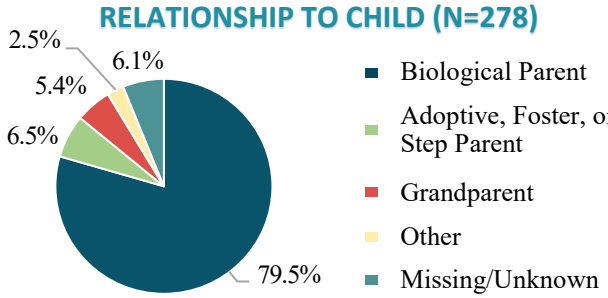
The majority of caregivers (78%) were between the ages of 26 and 59.

GENDER IDENTITY (N=278)



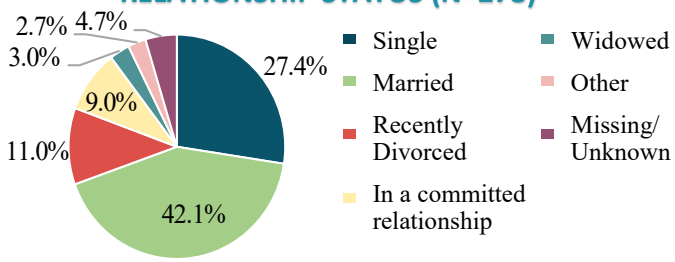
About three-quarters of caregivers were female (77%), and 14% of caregivers were male.

RELATIONSHIP TO CHILD (N=278)



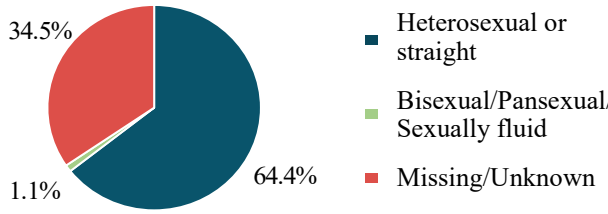
Most caregivers were a biological parent of the child receiving services (80%).

RELATIONSHIP STATUS (N=278)



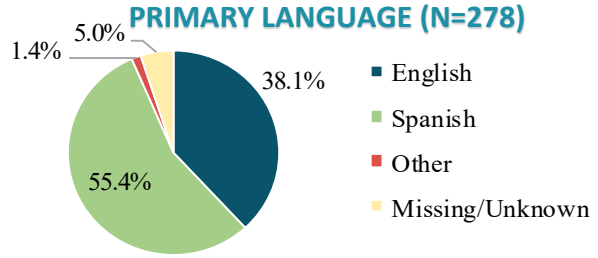
About one-quarter (27%) of caregivers were single, 42% were married, 11% were recently divorced, and 9% were in a committed relationship.

SEXUAL ORIENTATION (N=278)



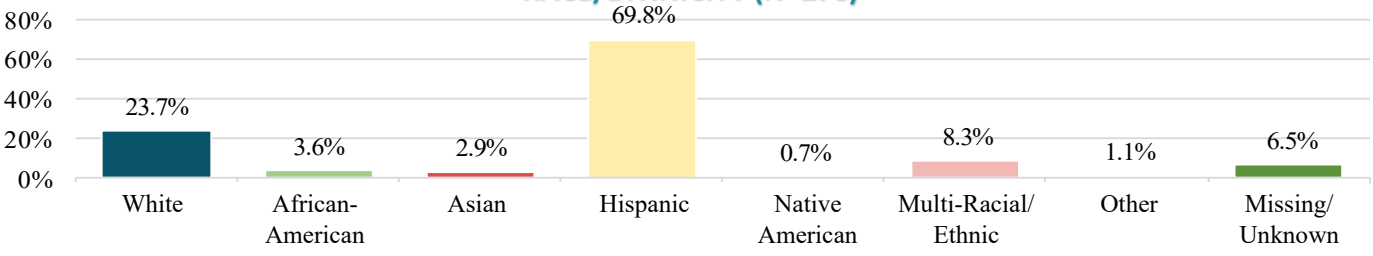
More than half (64%) of caregivers indicated they were heterosexual or straight, and about 1% indicated being bisexual, pansexual, or sexually fluid.

PRIMARY LANGUAGE (N=278)



Spanish was the primary language for the majority of caregivers (55%), with English as the primary language for 38% of caregivers.

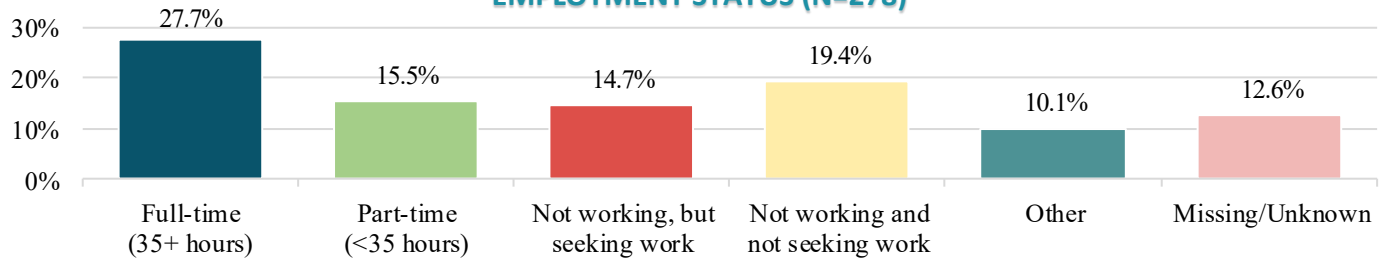
RACE/ETHNICITY (N=278)



Seventy percent of caregivers identified themselves as Hispanic. Of those caregivers, 39.6% specifically indicated being of Mexican origin. Totals may exceed 100% as caregivers were able to indicate more than one race/ethnicity.

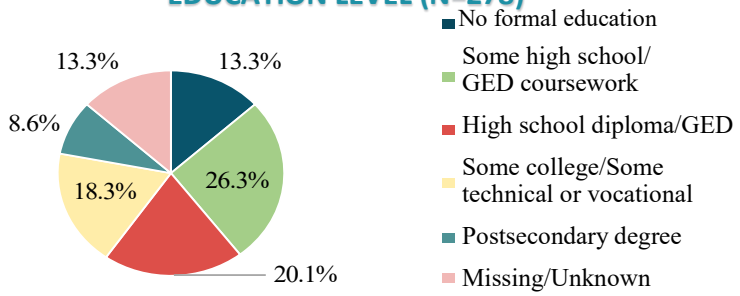
[1] *Caregiver demographic information was not required to be collected by participating FTPE programs prior to 1/1/2016. The charts include all available demographic information, which is expected to be generally representative of caregivers receiving FTPE services.*

EMPLOYMENT STATUS (N=278)



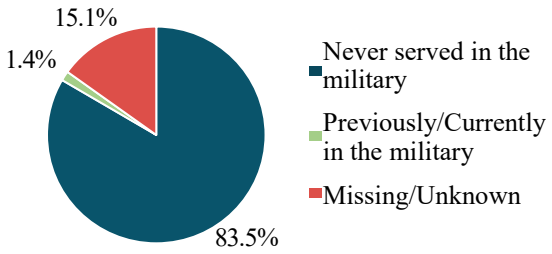
About one-quarter (28%) of caregivers worked full-time, 16% worked part-time, 15% were not working but seeking work, and 20% were not working and not seeking work.

EDUCATION LEVEL (N=278)



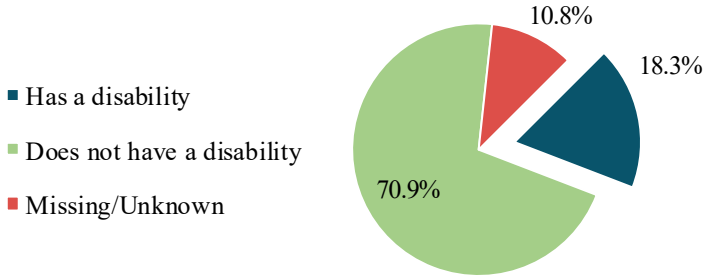
Caregivers' educational level was fairly split between several categories, the largest being some high school/GED coursework (26%).

MILITARY STATUS (N=278)



The majority (84%) of caregivers had never served in the military.

DISABILITY[1] STATUS (N=278)



Eighteen percent of caregivers had some type of non-SMI related disability.

TYPE OF DISABILITY (N=278)

Type	n	%
Communication	12	4.3
Mental (e.g., learning,)	12	4.3
Physical	17	6.1
Chronic Health	19	6.8
Other	11	4.0

This table describes the type of disability indicated by caregivers that had a as a percentage of total population. Caregivers may have indicated more than one disability.

[1] *A disability was 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 (SMI).*

KEY EVALUATION FINDINGS

OVERALL PROGRAM SERVICE PROVISION PRIOR TO AND AFTER INN FTPE IMPLEMENTATION

During Fiscal Year 2015-16, a total of 2,595 Parent Partner visits were provided to caregivers of 592 children receiving behavioral health treatment services at six Child, Youth and Family (CYF) programs throughout San Diego County. To help identify the overall impact of the FTPE program on Family Therapy participation, service utilization patterns at the Child, Youth, and Family (CYF) programs providing the new Parent Partner services through the FTPE program were examined before and after full FTPE program implementation. Two six-month blocks of time (1/1/2015 to 6/30/2015 and 1/1/2016 to 6/30/2016) were selected for this comparison.

TABLE 1. OVERALL SERVICE DISTRIBUTION PATTERNS BEFORE AND AFTER INN FTPE PROGRAM IMPLEMENTATION

	Before INN FTPE (1/1/2015 to 6/30/2015)	After INN FTPE (1/1/2016 to 6/30/2016)
Total Individual Therapy Sessions	8,989	8,467
Total Family Therapy Sessions	3,300	5,324
Total Parent Partner Visits	-	1,809
Ratio of Individual Therapy Sessions per each Family Therapy Session	2.7	1.6

As shown in the table above, the distribution of services provided by these CYF programs changed substantially before and after FTPE program implementation. The number of Family Therapy sessions increased greatly (3,300 to 5,324 = 61.3% increase) and the number of individual therapy sessions decreased slightly (8,989 to 8,467 = 5.8% decrease) between the six month reporting periods before and after the implementation of the FTPE program. This dropped the overall ratio of Individual Therapy sessions to Family Therapy sessions from 2.7 per family session to 1.6 per family session. These findings indicate a substantial shift in the overall number of Family Therapy sessions provided and in the distribution between Individual and Family Therapy sessions provided at these agencies. Feedback from program staff at the participating CYF agencies indicated that they were not aware of any other systemic changes that might have contributed to this shift in service utilization besides the implementation of the FTPE program.

SERVICE UTILIZATION OF FAMILIES ENTERING INN-12 CYF PROGRAMS PRIOR TO AND AFTER FTPE IMPLEMENTATION

The service utilization patterns of the families who began receiving services at these CYF programs (defined as no Family Therapy, Individual Therapy, or Parent Partner visits in the prior 6 months) during these two time periods were also examined. As shown in Table 2 on the next page, the service utilization patterns indicated that more caregivers participated in a least some Family Therapy sessions after the implementation of the FTPE program (70.9% vs. 58.5%). More importantly, the percentage of caregivers who more regularly participated in Family Therapy increased substantially after FTPE implementation (42.0% vs 26.8% averaged at least 1 session per month and 18.8% vs. 10.8% averaged at least 2 sessions per month). This means that after the implementation of the FTPE program, the number of families averaging at least 1 Family Therapy session per month increased by 57%, and number of families reaching the target threshold of 2 Family Therapy session per month increased by 74%. While additional work is needed to continue to bolster the number of families regularly participating in Family Therapy, the increase in the amount of participation following the implementation of FTPE was dramatic.

TABLE 2. SERVICE UTILIZATION PATTERNS BEFORE AND AFTER INN FTPE PROGRAM IMPLEMENTATION

	Before INN FTPE (1/1/2015 to 6/30/2015) (N=704)		After INN FTPE (1/1/2016 to 6/30/2016) (N=728)	
Individual Therapy	**%**	**n**	**%**	**n**
Had at least 1 session in the first 90 days of treatment	93.9%	661	89.4%	651
Averaged at least 1 session per month	81.0%	570	74.5%	543
Averaged at least 2 sessions per month	53.8%	379	43.3%	315
Family Therapy				
Had at least 1 session in the first 90 days of treatment	58.5%	412	70.9%	516
Averaged at least 1 session per month	26.8%	189	42.0%	306
Averaged at least 2 sessions per month	10.8%	76	18.8%	137
Parent Partner Visits				
Had at least 1 session in the first 90 days of treatment	-	-	36.1%	263
Averaged at least 1 session per month	-	-	18.7%	136
Averaged at least 2 sessions per month	-	-	6.6%	48

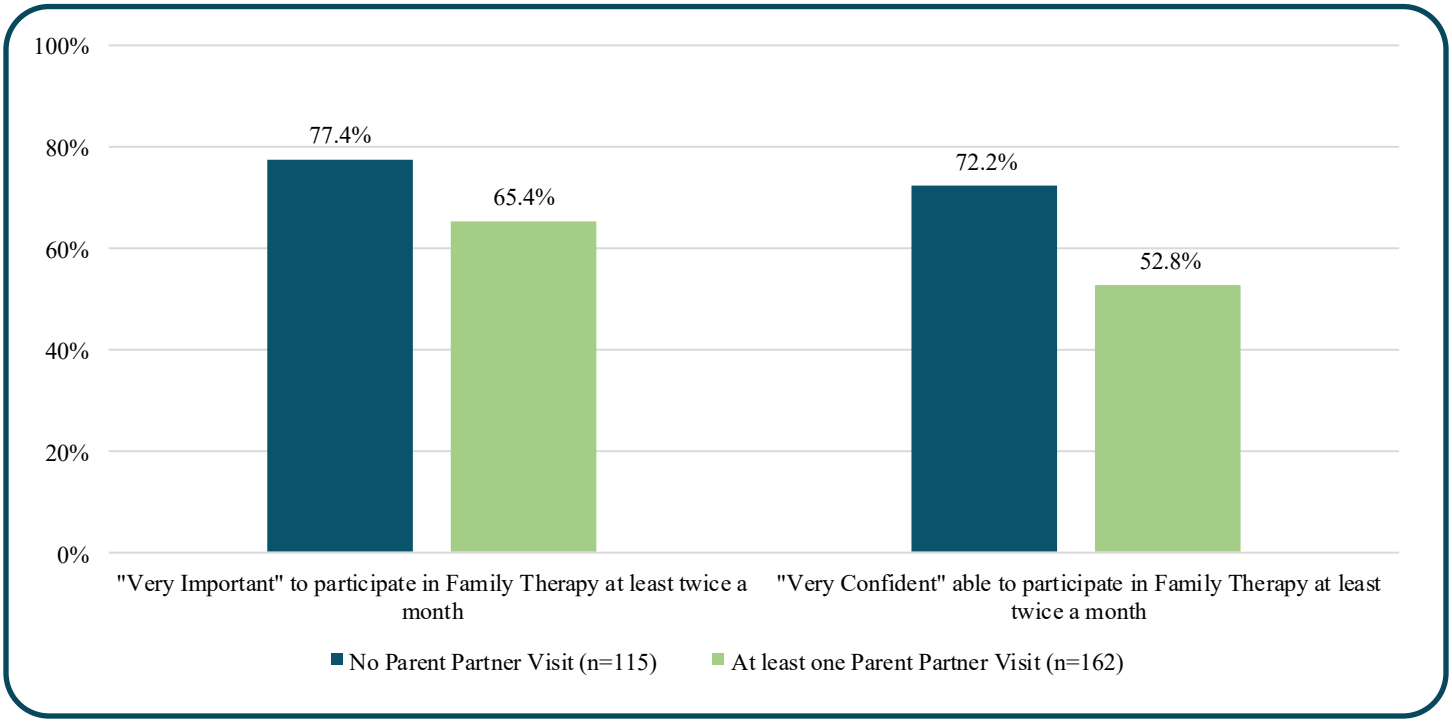
FAMILY THERAPY UTILIZATION AFTER INN FTPE PROGRAM IMPLEMENTATION

Out of the 728 children who entered into CYF programs after implementation of the FTPE program, 263 (36.1%) had caregivers that received at least 1 Parent Partner visit within 90 days of starting services, and 465 (63.9%) had caregivers that did not have a Parent Partner visit within 90 days of starting services. As shown in the Table 3 below, caregivers who received at least 1 Parent Partner visit were more likely to have participated in at least 1 Family Therapy session than those who did not have a Parent Partner visit (77.9% vs. 66.0%).

TABLE 3. RELATIONSHIP BETWEEN PARENT PARTNER VISITS AND FAMILY THERAPY PARTICIPATION

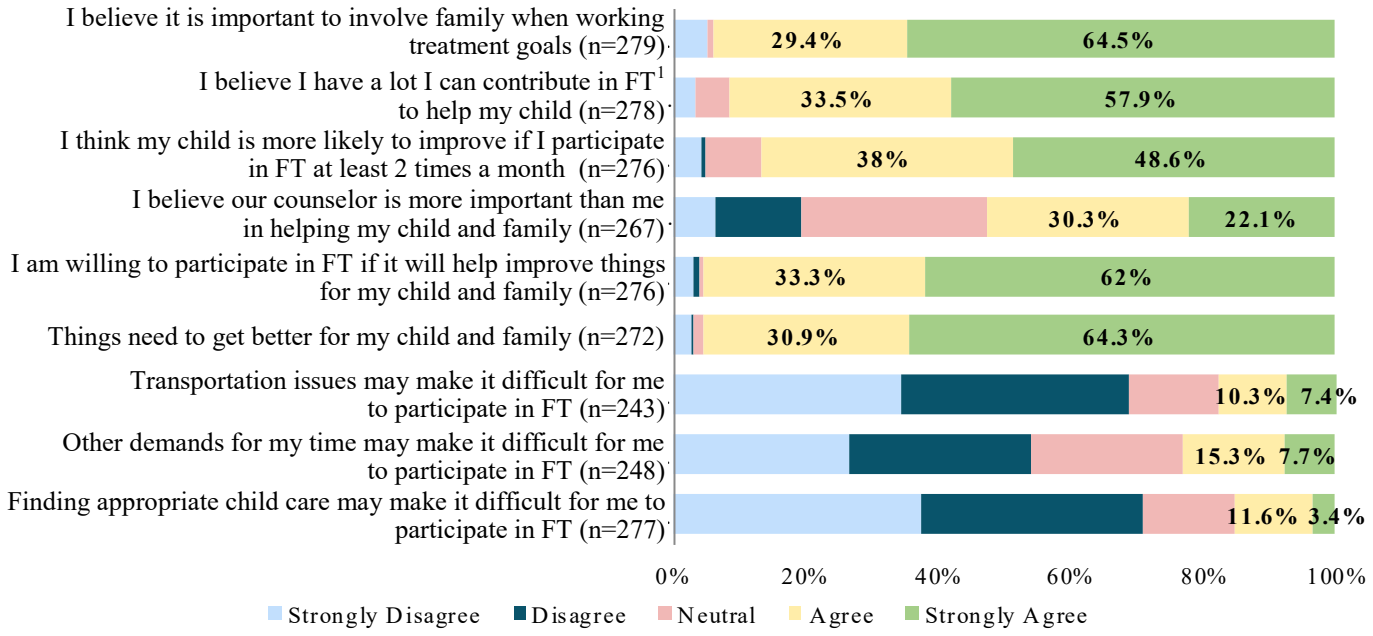
	No Parent Partner visits (1/1/2016 to 6/30/2016) (N=465)		Had at least 1 Parent Partner visit (1/1/2016 to 6/30/2016) (N=263)	
Family Therapy	**%**	**n**	**%**	**n**
Had at least 1 session in the first 90 days of treatment	66.0%	307	77.9%	205
Averaged at least 1 session per month	35.9%	167	53.2%	140
Averaged at least 2 sessions per month	15.1%	70	25.5%	67

The positive relationship between having a Parent Partner visit and increased participation in Family Therapy was especially evident when focusing on the percentage of children who reached the target threshold of averaging at least 2 Family Therapy sessions per month (25.5% vs. 15.1%). This difference is particularly significant given the fact that CYF programs reported seeking to direct their limited Parent Partner resources to caregivers who were considered most likely to not participate in Family Therapy. Based on data from the Caregiver Information survey administered to families when they first entered the CYF programs (see the chart below), the families who ended up receiving Parent Partner services were less likely to indicate that it was "Very Important" to participate in Family Therapy (65.4% vs. 77.4%) and less likely to indicate they were "Very Confident" that they would be able to participate in Family Therapy (52.8% vs. 72.2%). These findings suggest that the families receiving Parent Partner services were caregivers who were potentially less likely to participate in Family Therapy without some form of additional support. Thus, by providing Parent Partner visits, the FTPE program was able to obtain a higher proportion of caregivers meeting the target Family Therapy treatment threshold, especially among caregivers who were anticipated to be less likely to participate in Family Therapy.



CAREGIVER ATTITUDES ABOUT FAMILY THERAPY

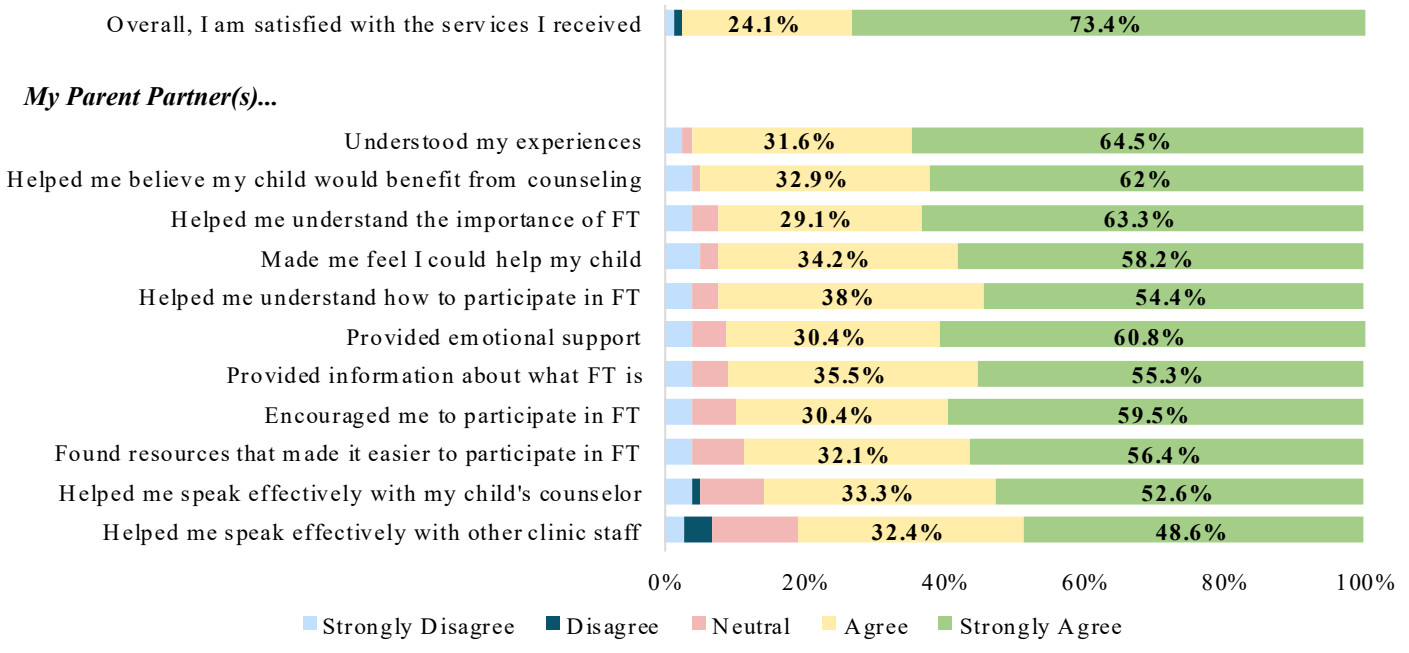
Overall, caregivers with children who first began to receive counseling services at the participating CYF programs prior to any Parent Partner visits expressed favorable attitudes about the importance of Family Therapy and their willingness to participate in Family Therapy, as shown in the chart below. Over 90% agreed or strongly agreed that it was important to involve family when working on child treatment goals and that they believed they had a lot to contribute in Family Therapy to help their child. However, there was more variability when asked about whether their counselor was more important than they were in helping their child and family (52.4% agreed or strongly agreed that the counselor was more important). Around 15-20% of caregivers agreed or strongly agreed that "tangible" barriers, such as transportation, child care, or other demands for their time would make it difficult for them to participate in Family Therapy.



[1] *FT stands for "Family Therapy."*

CAREGIVER FEEDBACK ON PARENT PARTNER SERVICES

At the conclusion of receiving short-term Parent Partner support services, caregivers were asked about their experiences with the Parent Partners (see chart on the following page). In particular, caregivers were asked about their satisfaction with the Parent Partner services and their perceptions of the Parent Partner(s). Based on the results presented below, caregivers were typically very satisfied with the Parent Partner services they received (97.5% indicated agreement or strong agreement with the satisfaction statements). The peer-support aspect of the Parent Partners likely contributed to the fact that almost all caregivers indicated (96.1% agreed or strongly agreed) that the Parent Partners "understood their experiences." Overall, the vast majority of caregivers agreed or strongly agreed that they received each type of support from their Parent Partners. The least common forms of support provided by Parent Partners were related to receiving assistance with how to communicate with the child's counselor and with other clinic staff.



Note: Not all caregivers who received Parent Partner visits completed the feedback survey. The results presented in this chart are based on the 79 follow-up surveys completed before 6/30/2016. Therefore, these results may not be representative of all caregivers receiving Parent Partner services.

FAMILY THERAPY PARTICIPATION ENGAGEMENT ANNUAL STAFF FEEDBACK SURVEY

At the end of the first year of providing FTPE services, program staff and others affiliated with the programs were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the FTPE program. We received 37 responses from 44 persons invited to participate in the survey, for a response rate of 84.1% (with a range of 67% to 100% across the individual programs). For the open-ended survey questions, at least two evaluators reviewed and coded the responses. Any discrepancies were discussed to arrive at a consensus on the key response themes.

1. *Major program goals identified by respondents:*
   a. Increasing caregiver participation in Family Therapy and in treatment more generally
   b. Improving child and family outcomes
   c. Providing education and advocacy for families
   d. Providing case management/support services
2. *Factors that helped the FTPE program achieve these goals:*
   a. The services that the Parent Partners provided (e.g., support, education, resources, working on obstacles)
   b. The training Parent Partners received on Motivational Interviewing and other important topics
   c. Parent Partners' lived experience
   d. The collaborative nature of the team approach to care (which included Parent Partners)
3. *Strategies most important for the success of the FTPE program:*
   a. Connecting with the caregiver consistently and early on in the program
   b. Using the MI approach (e.g., specific techniques to address ambivalence to Family Therapy, maintain the caregiver's autonomy, and assess the caregiver's needs and readiness to change),
   c. Providing education about topics like the benefits of Family Therapy and what to expect in treatment.
   d. Sharing the Parent Partner's own lived experience
   e. Providing emotional support to the caregivers
   f. Helping to reduce barriers
4. *Specific challenges to reaching the program goals described by respondents:*
   a. Low family attendance at services
   b. Caregiver ambivalence about services (both the Parent Partner service visits and treatment)
   c. Lack of resources like transportation and housing
   d. Caregivers' personal challenges (e.g., low literacy)
   e. Program barriers like high Parent Partner turnover

KEY YEAR 1 FAMILY THERAPY PARTICIPATION ENGAGEMENT PROGRAM "LEARNINGS"

1. Adding Parent Partners to the treatment team at CYF agencies substantially increased caregiver participation in Family Therapy sessions.
2. Caregivers typically reported having very positive experiences with their Parent Partners.
3. The "lived experience" or peer support model in which Parent Partners were required to have personal experience interacting with the children's behavioral health system was perceived to be an important component leading to successful engagement with caregivers.
4. The "lived experience" requirement, unique skill sets needed, and salary limitations made it challenging to identify and hire Parent Partners.
5. Motivational Interviewing and other trainings were crucial for equipping Parent Partners with the skills and tools they needed to connect with and support caregivers.
6. It was challenging and expensive to provide ongoing opportunities for Motivational Interviewing and other trainings for newly hired Parent Partners following staff turnover.
7. With agency support and encouragement (e.g., allowing time for provider planning meetings), Parent Partners played an important role in a team-based, collaborative care model in which therapists, case managers, and Parent Partners communicated with each other about how best to provide treatment, encouragement, and other support services to children and their caregivers.
8. Having Parent Partners who spoke Spanish was essential to meeting the service needs of the large population of San Diego County residents who primarily speak Spanish.
9. Besides potential language barriers, the caregivers served by Parent Partners often faced many other challenges to participating in Family Therapy, such as needs for child care, transportation, food assistance, and other supportive services. Caregivers frequently had low levels of formal education and were often unemployed.

YEAR 1 PROGRAM CHANGES

There were no changes to the INN-12 FTPE program that differed substantially from the initial design of the program during the first year of service provision (7/1/2015 to 6/30/2016). As is typical during program start-ups, some basic practices and procedures related to Parent Partner training, supervision, and service provision (e.g., when to first meet with caregivers) were adjusted over the course of the first year to better fit the context of the specific CYF agency. However, no fundamental or program-wide changes were made.

YEAR 1 PROGRAM RECOMMENDATIONS

Recommendations for how to improve the FTPE program and further increase caregiver participation in Family Therapy during Year 2 include the following:

1. Identify ways to provide additional opportunities for Motivational Interviewing and other trainings (e.g., parenting skills), particularly for newly hired Parent Partners.
2. Increase availability of Parent Partner services (e.g., provide additional Parent Partner FTE), so that more caregivers can have Parent Partners to support and encourage their participation in Family Therapy.
3. Increase use of group meetings between caregivers and Parent Partners to encourage greater caregiver social supports.
4. Identify and/or directly provide additional resources to address the "tangible" barriers to Family Therapy participation, such as transportation and child care.
5. Seek out ways to encourage and support the Parent Partners (e.g., employee recognition, opportunities for peer-support between Parent Partners at different CYF agencies, increased pay or other benefits) to communicate importance of this position and potentially reduce turnover.

For additional information about the INN–12 Family Therapy Participation Engagement program and/or this annual report, please contact: David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

Participant Demographics: INN 12 Family Therapy Participation Engagement Program

Supplemental Summary

Age	**N**	**%**
0-15 (children/youth)	0	*0%*
16-25 (transition age youth)	11	*4.0%*
26-59 (adult)	216	*77.7%*
60+ (older adults)	4	*1.4%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	47	*16.9%*
TOTAL	**278**	***100%***

Race	N	%
Black/African American	10	*3.6%*
Asian	6	*2.2%*
White	62	*22.3%*
Native American	2	*0.7%*
More than one race	4	*1.4%*
Other	1	*0.4%*
Unknown/preferred not to answer	6	*2.2%*
Missing/did not answer	187	*67.2%*
TOTAL	**278**	***100%***

Ethnicity	**N**	**%**	**N**	**%***
Hispanic or Latino	175	*62.9%*		
Central American			1	*0.4%*
Mexican			104	*37.4%*
Other			11	*3.9%*
Missing/did not answer			60	*21.6%*
Non-Hispanic or Non-Latino	66	*23.7%*		
European			2	*0.7%*
Iraqi			1	*0.4%*
Japanese			1	*0.4%*
Other			10	*3.6%*
Missing/did not answer			52	*18.7%*
More than one ethnicity	19	*6.8%*	9	*3.2%*
Unknown/preferred not to answer	6	*2.2%*	6	*2.2%*
Missing/did not answer	12	*4.3%*	12	*6.5%*
TOTAL	**278**	***100%***		

* Totals may add to more than 100% since participants could indicate multiple subethnicities.

Primary Language	N	%
Arabic	1	*0.4%*
Armenian	1	*0.4%*
English	106	*38.1%*
Spanish	154	*55.4%*
Other	2	*0.7%*
Unknown/preferred not to answer	5	*1.8%*
Missing/did not answer	9	*3.2%*
TOTAL	**278**	***100%***

Sexual Orientation	N	%
Heterosexual or Straight	179	*64.4%*
Bisexual	3	*1.1%*
Unknown/preferred not to answer	52	*18.7%*
Missing/did not answer	44	*15.8%*
TOTAL	**278**	***100%***

Disability	N	%	N	%*	N	%*
Yes disability	51	*18.3%*				
Communication disability			12	*4.3%*		
Difficulty seeing					8	*2.9%*
Difficulty hearing/speaking					7	*2.5%*
Mental disability			12	*4.3%*		
Learning disability					6	*2.2%*
Other mental disability					7	*2.5%*
Physical/mobility disability			17	*6.1%*	17	*6.1%*
Chronic health condition			19	*6.8%*	19	*6.8%*
Other disability			11	*4.0%*	11	*4.0%*
No disability	197	*70.9%*	197	*70.9%*	197	*70.9%*
Unknown/preferred not to answer	0	*0%*	0	*0%*	0	*0%*
Missing/did not answer	30	*10.8%*	30	*10.8%*	30	*10.8%*
TOTAL	**278**	***100%***				

* Totals may add to more than 100% since participants could indicate multiple disabilities.

Veteran Status	N	%
Yes	8	*2.9%*
No	230	*82.7*
Unknown/preferred not to answer	24	*8.6%*
Missing/did not answer	16	*5.8%*
TOTAL	**278**	***100%***

Gender: Assigned Sex at Birth	N	%
Male	23	*8.3%*
Female	231	*83.1%*
Unknown/preferred not to answer	11	*3.9%*
Missing/did not answer	13	*4.7%*
TOTAL	**278**	***100%***

Gender: Current Gender Identity	N	%
Male	25	*9.0%*
Female	213	*76.6%*
Unknown/preferred not to answer	19	*6.8%*
Missing/did not answer	21	*7.6%*
TOTAL	**278**	***100%***

FAITH-BASED INITIATIVE PROGRAMS (INNOVATIONS-13)

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

STATUS AS OF 6/30/16

The Faith-Based Initiative (FBI) is funded through the Innovations (INN) component of the Mental Health Services Act. Primary goals of the FBI are to: 1) develop meaningful collaborations and partnerships between Behavioral Health Services (BHS) and faith-based leaders; 2) increase BHS outreach and engagement within faith-based communities; 3) increase education and training about BHS; and 4) provide faith-based leaders and community members with information about where and how to access mental health services, alcohol and drug services, and other resources for children, adults, and older adults. FBI programs are focused primarily on African-American and Latino communities, who have traditionally been disproportionately served in the jail system and have had limited access to appropriate and culturally relevant BHS services. FBI services are designed to promote cross-education among both BHS and the faith-based community, as well as reduce the effects of untreated mental illness for community members. To achieve these overall goals, the FBI is divided into four Task Orders that target specific needs identified within the faith-based community.

Faith Based Academy (FBA) FBI Task Order #1 (TO1). The primary objective of TO1 is to recruit faith-based leaders and behavioral health providers to collaborate in developing an educational curriculum—one that specifically addresses faith/spirituality principles and values, wellness, mental health conditions, and resource information tailored for African-American and Latino communities. Through these Faith-Based Academies, faith-based and behavioral health "champions" will be identified, who will then train Facilitator Trainers (FT) to conduct education and outreach presentations throughout the community.

Community Education (CE) FBI Task Order #2 (TO2). TO2 is designed to have the faith-based and behavioral health "champions" identified in TO1 train program staff called Facilitator Trainers (FT) to provide educational presentations in the community using the approved FBA curriculum educational toolkit designed in TO1. Community education will be jointly provided by faith-based and Behavioral Health FTs.

Crisis Response (CR) FBI Task Order #3 (TO3). Through TO3, a supportive, trauma-informed, and strength-based crisis intervention protocol will be developed. The faith-based Crisis Response team will be on-call 24/7 to respond rapidly to individual or family crisis situations (e.g., suicides, homicides, domestic violence). The faith-based Crisis Response team will also provide follow-up support services and facilitate linkages to BHS and other community resources as needed.

Jail In-reach Health and Wellness Ministry (JIHWM) FBI Task Order #4 (TO4). A primary objective of TO4 is to develop a faith-based team that will outreach to adults in jail who are diagnosed with an SMI prior to their release, providing spiritual support consistent with the individual's faith and information regarding mental health and physical health wellness. The team will also provide support services and linkages to community-based resources to facilitate individuals' re-integration back into the community.

EXECUTIVE SUMMARY

Curriculum development work for the Faith-Based Academy (Task Order 1) began prior to 6/30/2016 but was still in progress at that time. Task Orders 2, 3, and 4 had not started service provision activities prior to 6/30/16.

Evaluation results for each FBI Task Order will be included in the next INN Annual Report cycle.

For additional information about the INN–13 Faith-Based Initiative programs please contact:
David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

NOBLE WORKS (INNOVATIONS-14)

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

ANNUAL REPORT: YEAR 1 (7/1/15 - 6/30/16)

The Noble Works program is funded through the Innovations (INN) component of the Mental Health Services Act. Noble Works is designed to increase employment of persons with severe mental illness (SMI), with a particular emphasis on expanding employment opportunities beyond traditional low-wage, low-skill positions. Through improvements in their employment situation, Noble Works is expected to also boost participants' sense of empowerment, social connectedness, and overall quality of life. The Union of Pan Asian Communities (UPAC) is the lead agency in the Noble Works collaboration, with Pathways Community Services providing employment services oriented towards transitional age youth (TAY), and the National Alliance on Mental Illness San Diego (NAMI SD) providing community presentations and other training supports.

Noble Works utilizes a multi-faceted approach based on Supported Employment principles that target both prospective employers and persons with SMI. Core components of the program include utilization of Employment Specialists, who help participants prepare for and find competitive employment positions of interest, and peer-support Job Coaches, who provide individualized support for maintaining employment. UPAC and NAMI SD conduct community presentations to help reduce stigma and educate potential employers about hiring persons with SMI. Other innovative Noble Works components include: funding for apprenticeships to incentivize hiring persons with SMI, access to the NAMI SD Tech Café, technology-related training and certificate opportunities (e.g., CompTIA A+), entrepreneurial business development supports, and other resources to facilitate acquisition of desired employment opportunities.

EXECUTIVE SUMMARY

The Noble Works program (INN-14) is designed to increase competitive employment among persons with SMI by providing extensive pre- and post-employment training and support via Noble Works Employment Specialists and Job Coaches. Noble Works program activities also include outreach to and education of potential employers to decrease stigma and expand awareness of employment opportunities for Noble Works participants.

- The Noble Works contract was awarded 8/1/2015, and services started 12/1/2015. During Fiscal Year 2015-16, a total of 77 persons with SMI entered the Noble Works program.
- Upon entry into Noble Works, almost half of the participants (44.2%) had a high school level education or less, about two-thirds (64.9%) reported they had a non-SMI related disability, and 71.4% indicated they were not working but seeking work.
- Approximately 70-80% of participants agreed/strongly agreed that they were engaged in activities relevant to successful job search and acquisition at the start of the program (e.g., learning new things, working towards goals, using personal strengths, etc.). Only about 25% thought they had sufficient income.
- Positive employment-relevant changes occurred at follow-up, indicated by participants reporting improved job satisfaction, dealing more effectively with problems, experiencing reduced symptoms, having more income, and working on goals.
- At follow-up, job satisfaction was positively associated with other indicators of participant well-being (e.g., self-fulfillment, quality of life), which indicated that as job satisfaction increased, other life domains improved as well.
- As of 6/30/2016, participants acquired a total of 11 jobs through Noble Works, with an average wage of $11.48/hour (range: $11-$19/hour) and 29.3 hours per week (5 jobs were full-time). Participants still employed as of 6/30/2016 had worked for an average of 60.7 days total.
- Noble Works staff identified the following key factors that helped achieve program goals: 1) program structure/flexibility to work with both participants and employers, 2) staff skills and passion, 3) NAMI SD partnership for community outreach and stigma reduction, 4) Pathways partnership to recruit and serve TAY, 5) motivated participants, and 5) access to tools and resources to support participants (e.g. class curriculum, etc.).
- Primary factors inhibiting achievement of program goals included high staff turnover, challenges with program "start-up", maintaining participant engagement, and finding desired and relevant employment opportunities for participants.

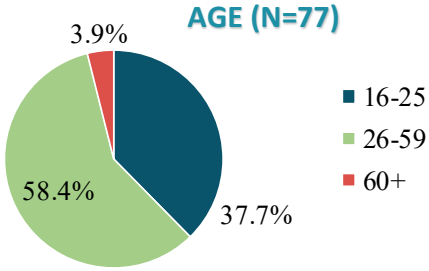
RECOMMENDATIONS

Primary recommendations include: 1) maintain full staffing levels and minimize turnover, 2) increase awareness of Noble Works, 3) identify strategies to support participant engagement in Noble Works (e.g., incentives, frequent "check-ins", etc.), 4) improve coordination and communication between staff roles and agency partners, 5) Maximize amount of time spent working directly with each participant, and 6) periodic review/fidelity checks between Noble Works practices and Supported Employment principles.

NOBLE WORKS PROGRAM PARTICIPANT DEMOGRAPHICS

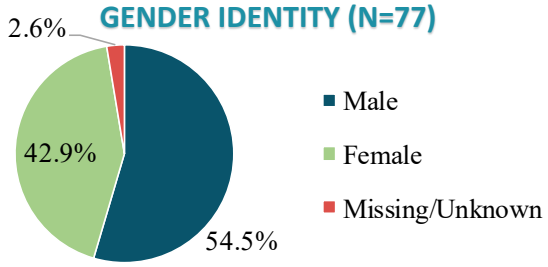
The following demographic data were collected from a participant self-report survey administered at the start of Noble Works.

AGE (N=77)



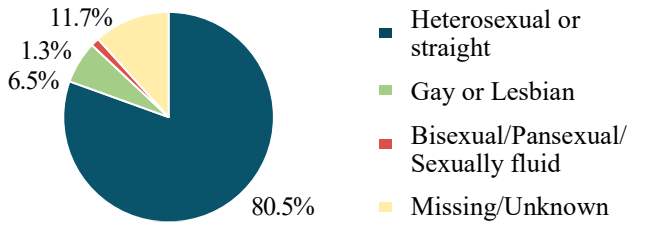
Over half (58%) of participants were between the ages of 26 and 59.

GENDER IDENTITY (N=77)



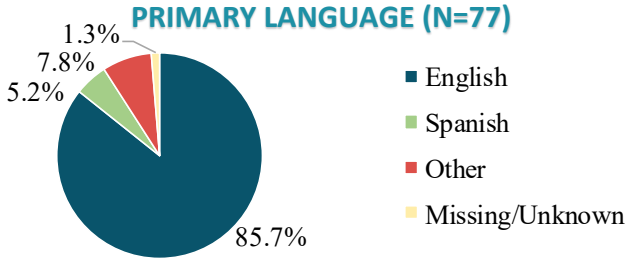
Over half (55%) of participants were male, and 43% were female.

SEXUAL ORIENTATION (N=77)



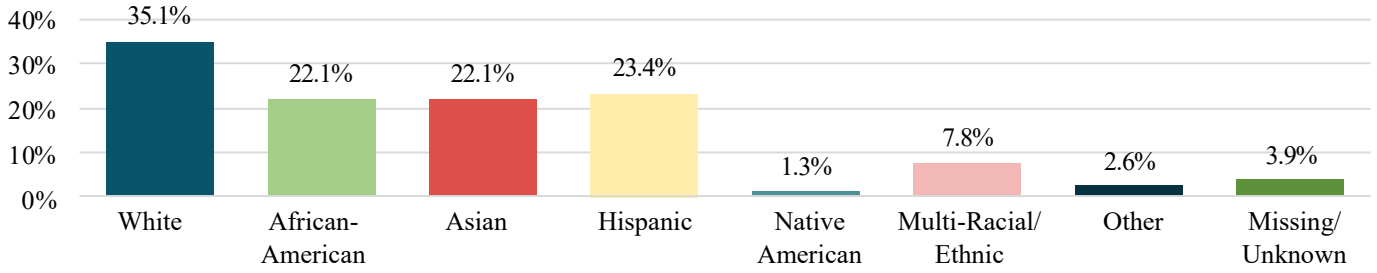
The majority (81%) of participants were heterosexual or straight, and 7% indicated being gay or lesbian.

PRIMARY LANGUAGE (N=77)



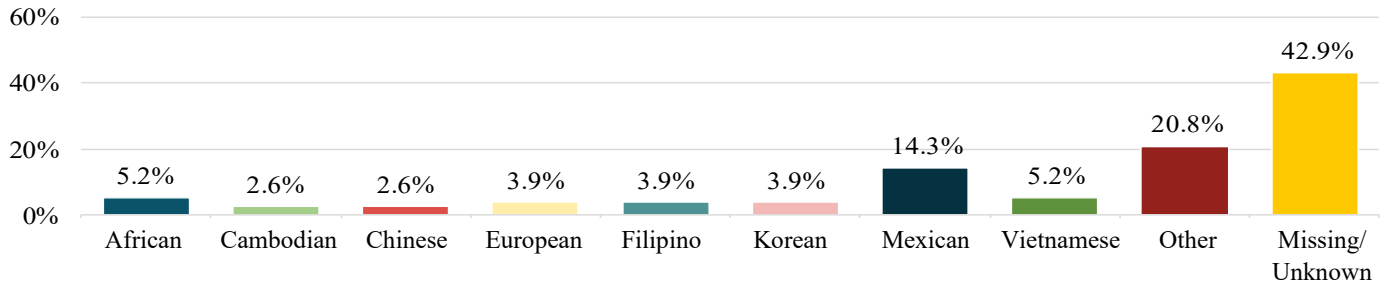
English was the primary language for the majority (86%) of participants, with Spanish being the primary language for 5% of participants.

RACE/ETHNICITY (N=77)



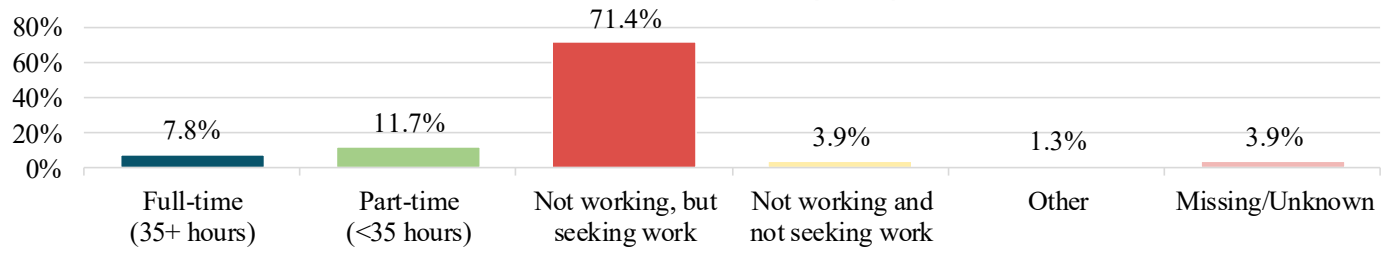
Thirty-five percent of participants identified themselves as White. Totals may exceed 100% as participants could indicate more than one race/ethnicity.

ETHNIC BACKGROUND (N=77)



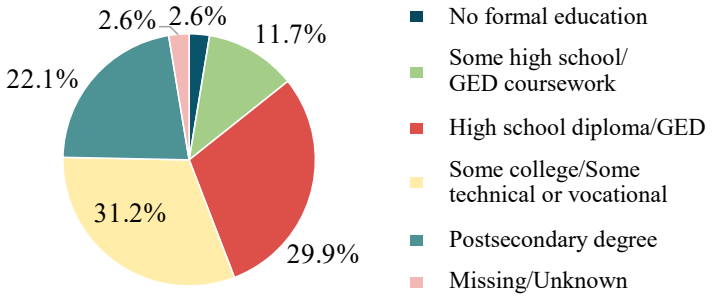
Fourteen percent of participants indicated being of Mexican origin. Totals may exceed 100% as participants could indicate more than ethnic background.

EMPLOYMENT STATUS (N=77)



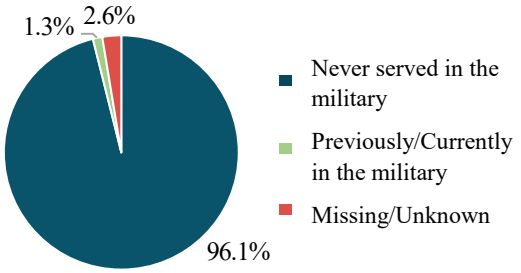
Almost three-quarters (71%) of participants were not working but seeking work. Totals may exceed 100% as participants could select more than one employment status category.

EDUCATION LEVEL (N=77)



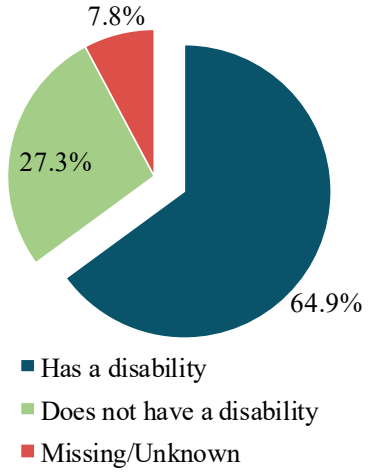
Thirty percent of participants had achieved a high school diploma or GED, and 31% had taken some college or technical/vocational courses.

MILITARY STATUS (N=77)



The majority (96%) of participants had never served in the military.

DISABILITY[1] STATUS (N=77)



Sixty-five percent of participants indicated having some form of non-SMI disability.

TYPE OF DISABILITY (N=77)

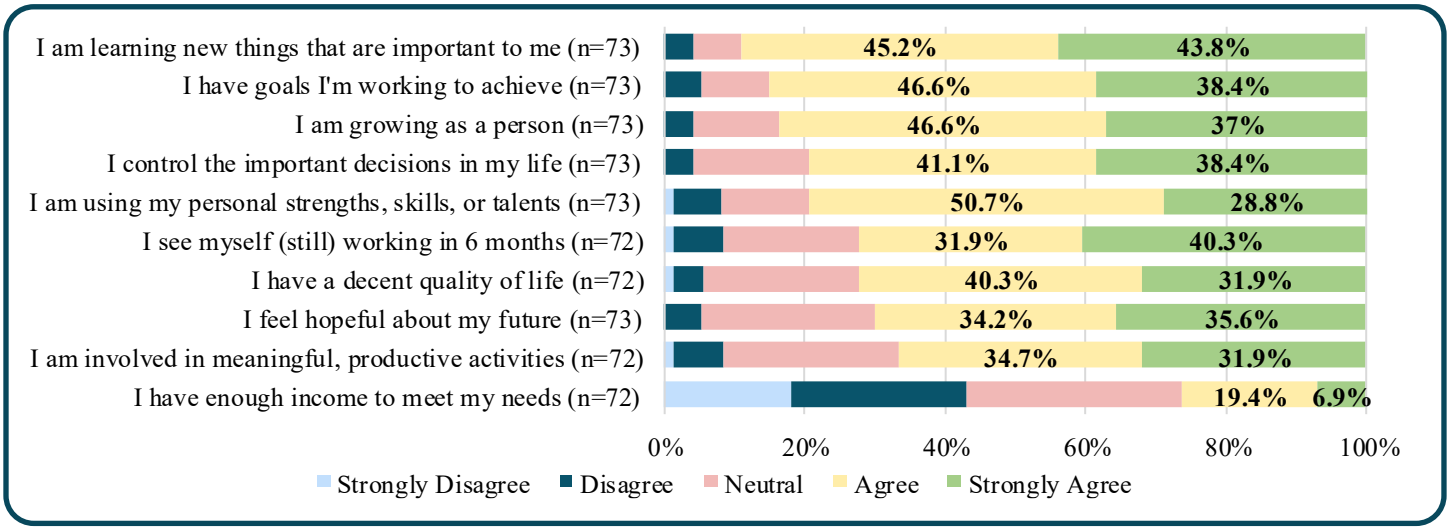
Type	n	%
Communication	13	16.9
Mental (e.g. learning, developmental)	25	32.5
Physical	4	5.2
Chronic Health	7	9.1
Other	20	26.0

This table describes the type of disability indicated by participants that had a disability, as a percentage of the total population. Totals may exceed 100% as participants could indicate more than one type of disability.

[1] *A disability was 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 (SMI).*

KEY EVALUATION FINDINGS: BASELINE

Upon entering Noble Works, participants completed a baseline survey, which included the Recovery Markers Questionnaire (RMQ) and items from the Brief Index of Affective Job Satisfaction (BIAJS). Results from this survey are shown in the following charts. Select items from the RMQ deemed relevant to the employment-focused outcomes of the program are presented in the chart below in order of highest to lowest percentage of agreement (i.e., indicated Agree or Strongly Agree). The majority of respondents indicated that they agreed or strongly agreed with many of the RMQ items, with the most commonly endorsed items being: "I am learning new things that are important to me", "I have goals I'm working to achieve", and "I am growing as a person" (89.0%, 85.0%, and 83.6%, respectively). The least commonly endorsed item was: "I have enough income to meet my needs" (26.3% agreed or strongly agreed). Participants' responses to these RMQ items suggest that many Noble Works participants felt positively about their overall life satisfaction and their prospects of accomplishing future goals even from the outset of the program, but lack of sufficient income was still a major presenting need for many of these participants.



KEY EVALUATION FINDINGS: FOLLOW-UP

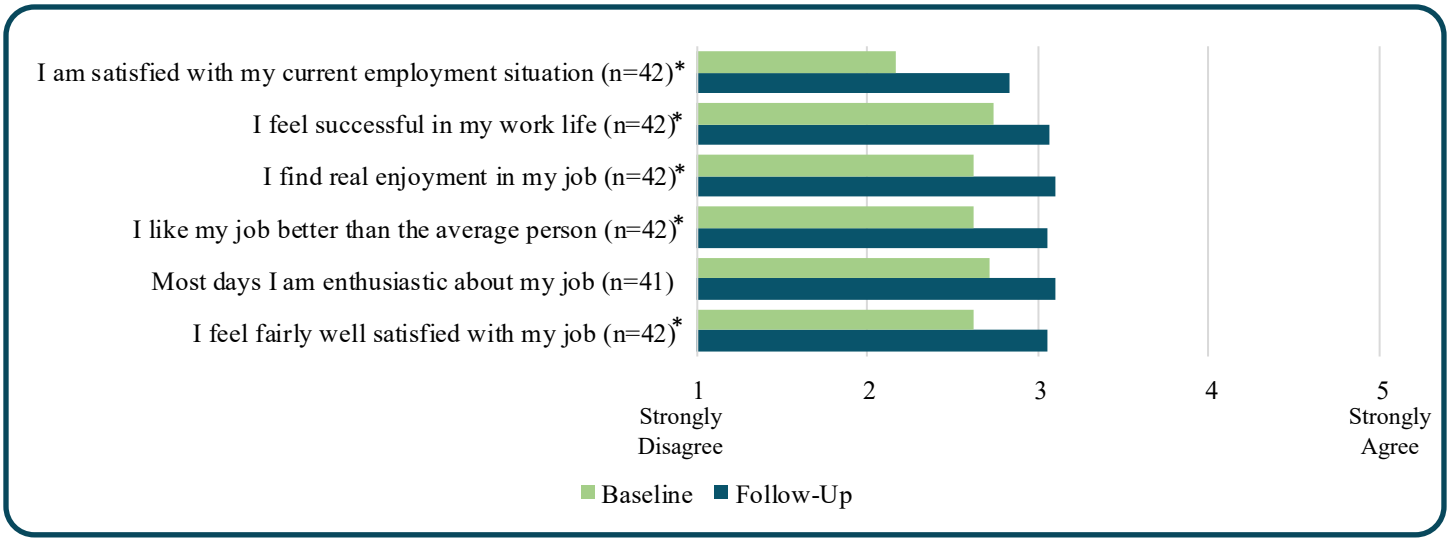
Approximately 90 days after entering Noble Works, participants were asked to fill out a follow-up survey, which also included the RMQ and items from the BIAJS. While samples sizes were relatively small, several items from the RMQ suggested areas of change compared to baseline. Starred items in Table 1 had a statistically significant change in mean score from baseline to follow-up; the other items listed showed potential for significant change if the patterns persist with a larger sample size. Indicators related to primary target outcomes of Noble Works, such as increased income, working on goals, coping with symptoms, and dealing effectively with problems all improved at follow-up. However, participants indicated lower ratings of learning new things and feeling hopeful about the future at follow-up. It is unclear at this time why these ratings changed in a negative way; it is possible that initial participant expectations may not have been met. These change patterns will continue to be assessed in future reporting periods with larger sample sizes.

TABLE 1. QUANTITATIVE ASSESSMENT OF CHANGES IN PERCEPTIONS OF NOBLE WORKS PARTICIPANTS

	Change in Mean Score
I have enough income to meet my needs (n=42)	Improved at follow-up
I have goals I'm working to achieve (n=43)	Improved at follow-up
My symptoms are bothering me less since starting services here (n=43)	Improved at follow-up
I deal more effectively with daily problems since starting services here (n=43)	Improved at follow-up*
I am learning new things that are important to me (n=43)	Worsened at follow-up*
I feel hopeful about my future (n=43)	Worsened at follow-up*

* Statistically significant change.

The 90-day follow-up survey also included job-related items from the RMQ and BIAJS, and the results from baseline and follow-up are depicted in the chart below. Starred items had a statistically significant change in mean score from baseline to follow-up. While not all of these participants were employed, the responses to items such as "I am satisfied with my current employment situation" and "I feel successful in my work life" provided a more generalized assessment of participants' work life perceptions. The average score across all six items increased from 2.6 at baseline to 3.0 at follow-up on a scale from 1 (strongly disagree) to 5 (strongly agree). The statistically significant increases suggest that participation in Noble Works was associated with a more positive outlook on their employment circumstances; however, there was still substantial opportunity for further improvements.



As shown in Table 2, at follow-up, a number of items from the RMQ correlated with overall job satisfaction. These correlations indicated positive associations between how the participant felt about their employment situation and a range of other life domains related to their self-fulfillment, social connectedness, symptom reduction, and quality of life. While a causal relationship cannot be determined through these analyses, there seemed to be strong relationships between job satisfaction and many of the other life domains that Noble Works intended to improve through increased employment opportunities. These results support the initial design of the Noble Works program and merit further examination as more data becomes available. It is also interesting to note that having enough income was *not* related to job satisfaction at follow-up.

TABLE 2. CORRELATIONS BETWEEN RMQ ITEMS AND OVERALL JOB SATISFACTION AT FOLLOW-UP

	Overall Job Satisfaction at Follow-Up
RMQ Responses at Follow-Up	**Correlation**
I am using my personal strengths, skills, or talents	.544**
I am learning new things that are important to me	.496**
I have a sense of belonging	.469**
I have a decent quality of life	.463**
I have reasons to get out of bed in the morning	.436**
I am growing as a person	.409**
My symptoms are bothering me less since starting services here	.407**
I am involved in meaningful, productive activities	.406**
I have enough income to meet my needs	.112

** Statistically significant change, p<.01.

JOBS ACQUIRED THROUGH NOBLE WORKS

A total of 11 jobs were acquired through the Noble Works program as of 6/30/2016. As shown in Table 3, the most common job domains for these positions were in sales and office/administrative support (36.4% and 27.3%, respectively).

TABLE 3. JOB DOMAIN

	n	%
Building and Grounds Cleaning and Maintenance Occupations	1	9.1
Food Preparation and Serving Related Occupations	1	9.1
Healthcare Support Occupations	1	9.1
Office and Administrative Support Occupations	3	27.3
Protective Service Occupations	1	9.1
Sales and Related Occupations	4	36.4

The average wage for these positions was $11.48 per hour. Almost half of the jobs (45.5%) were full-time, with 29.3 hours worked per week on average. Of the seven ongoing jobs as of 6/30/2016, the average duration was 60.7 days. Of the four jobs that ended prior to 6/30/2016, two were due to factors outside of the control of the Noble Works participant (i.e., store closing/job ending).

$11.48
AVERAGE WAGE

Range: $10-19/hour

- 6 jobs (54.5%) paid $10 per hour (California minimum wage during this time)

29.3
HOURS/WEEK

Range: 12-40 hours/wk

- 5 jobs (45.5%) were "full-time" (i.e., 35 hours or more per week)

60.7
DAYS WORKED

Range: 11-122 days

- 7 jobs (63.6%) were ongoing as of 6/30/2016

50.3
DAYS WORKED

Range: 10-93 days

- 4 jobs (36.3%) ended prior to 6/30/2016

Based on the U.S. Department of Labor Occupational Information Network (O*NET) Standard Occupational Classifications (SOC), most of the jobs obtained through the Noble Works program required either little/no preparation (36.6%) or some preparation (45.5%). These preparation levels were consistent with the finding that the majority of positions (54.5%) started at minimum wage. As the Noble Works program expands their network of employers and provides more sophisticated training (e.g., CompTIA), it is expected that the job zone classifications and average wage will increase.

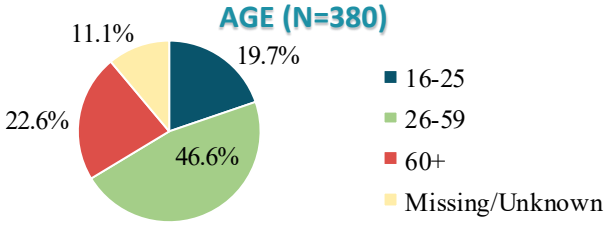
TABLE 4. O*NET SOC JOB ZONES

	n	%
1 - Occupations that need little or no preparation	4	36.3
2 - Occupations that need some preparation	5	45.5
3 - Occupations that need medium preparation	2	18.2

COMMUNITY PRESENTATION DEMOGRAPHICS AND OUTCOMES

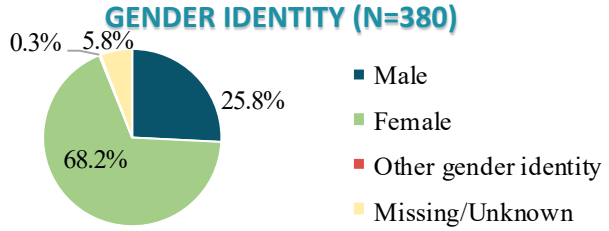
NAMI SD, as a Noble Works program partner, conducted 39 community outreach, education, and "In Our Own Voice" (IOOV) presentations regarding mental illness and recovery in their ongoing efforts to reduce mental health stigma in the community. Based on feedback data, less than half of the attendees (47.6%) were aware of NAMI prior to the presentation they attended. This suggests that NAMI SD was reaching many community members who were not well-informed about mental health issues, services, and recovery. For certain outreach events with potential employer organizations, Noble Works representatives also provided "Employer Wellness" presentations. The charts below provide an overview of select presentation attendee demographics and outcomes.

AGE (N=380)



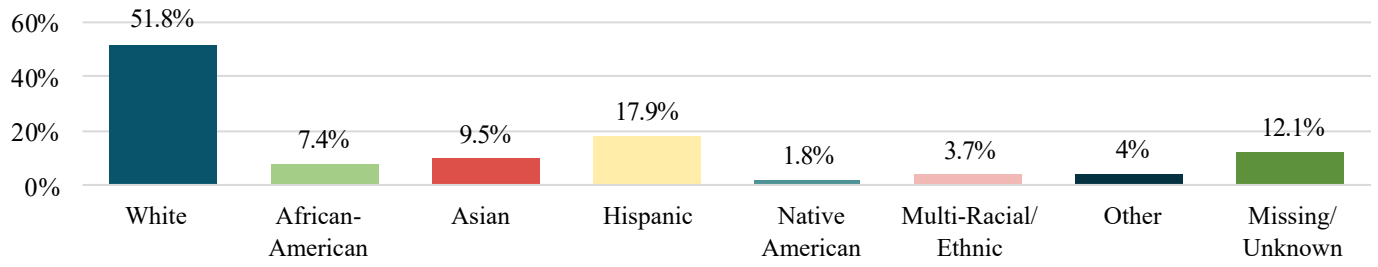
About half (47%) of attendees were between 26 and 59.

GENDER IDENTITY (N=380)



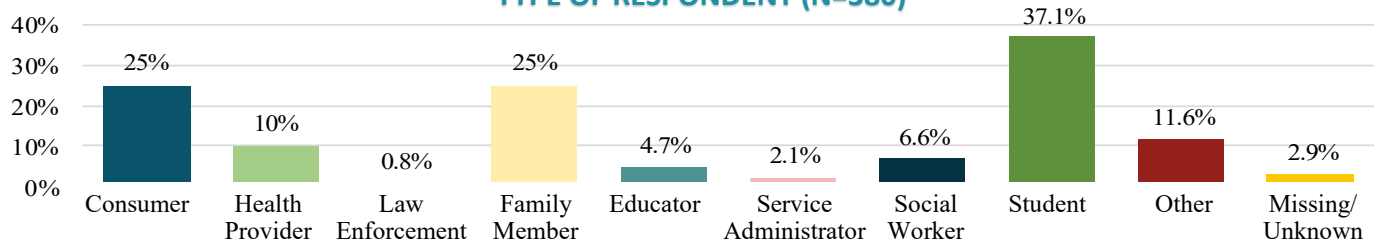
Attendees were 65% female and 25% male.

RACE/ETHNICITY (N=380)



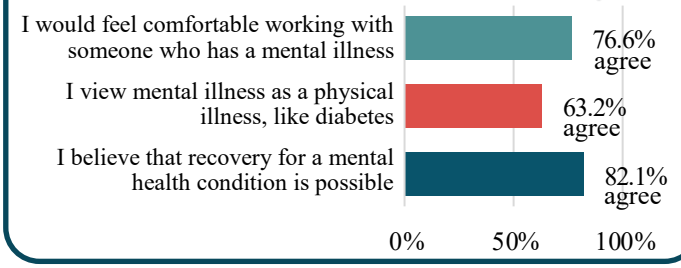
More than half (52%) of attendees identified themselves as White, and one-fifth (20%) identified as Hispanic. Totals may exceed 100% as attendees could indicate more than one race/ethnicity.

TYPE OF RESPONDENT (N=380)

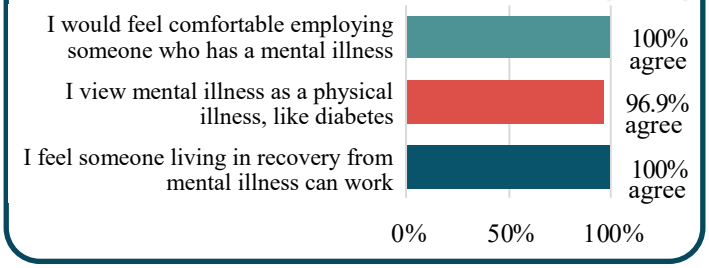


Thirty-seven percent of attendees identified themselves as students, one-quarter (25%) identified as consumers, and one-quarter (25%) identified as family members. Totals may exceed 100% as attendees could indicate more than category.

NAMI SD IOOV PRESENTATION OUTCOMES (N=380)



NOBLE WORKS PRESENTATION OUTCOMES (N=22)

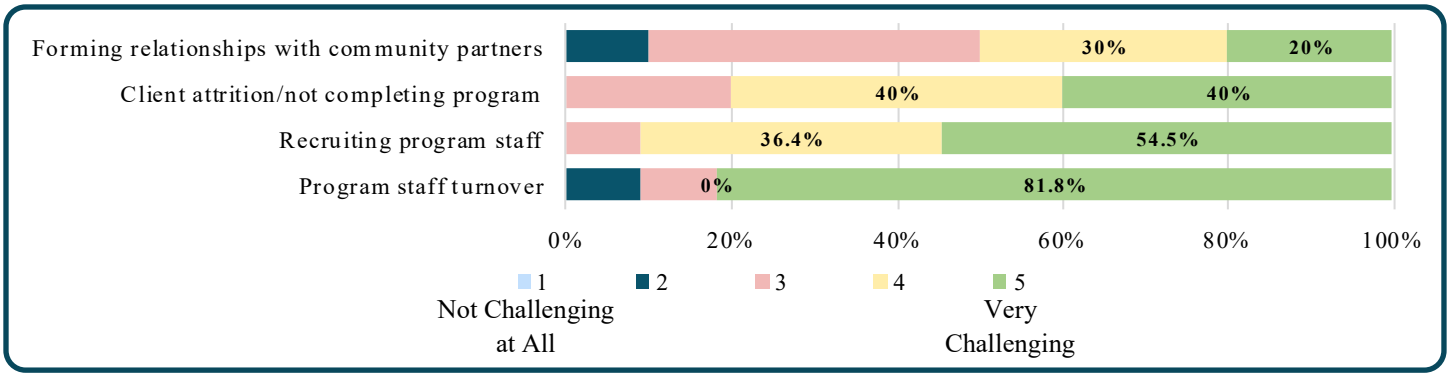


The majority of respondents indicated positive attitudinal changes as a result of NAMI SD's IOOV presentation. While the number of Noble Works "Employer Wellness" presentation attendees was smaller, nearly all indicated positive attitudinal changes.

NOBLE WORKS PROGRAM ANNUAL STAFF FEEDBACK SURVEY

At the end of the first year of providing the INN Noble Works program, administrative and provider staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the Noble Works program. We had 12 respondents from the 14 persons invited to participate in the survey, for a response rate of 85.7%. For the open-ended survey questions, at least two evaluators reviewed and coded the responses, and any discrepancies were discussed to arrive at a consensus on the key response themes.

The chart below highlights key Year 1 programmatic difficulties identified by Noble Works staff. Many staff regarded forming community partnerships and client attrition as challenges for the Noble Works program. Concerns about staffing were even more salient, with 54.5% indicating that it was very challenging to recruit staff and 81.8% indicating that staff turnover was a very challenging issue for the program.



1. *Primary goals of the Noble Works program as identified by survey respondents:*
   a. Increase employment opportunities by identifying and educating potential employers
   b. Increase employment opportunities through education and skill-building of participants
   c. Reduce mental health stigma in community and workplace
2. *Factors that facilitated the achievement of program goals:*
   a. Program structure/flexibility allowed for supporting and educating both participants and employers
   b. Staff skills and passion to support participants and work towards overall program goals
   c. Partnership with NAMI SD to utilize the "In Our Own Voice" presentation for community outreach and stigma reduction
   d. Partnership with Pathways to recruit and provide Noble Work service to transitional age youth
   e. Participants who were motivated and engaged in program activities
   f. Program tools/resources available to educate and support participants (e.g., class curriculum, NAMI SD Tech Café, etc.)
3. *Factors that inhibited the achievement of program goals:*
   a. High staff turnover
   b. Time and energy needed for program start-up activities and learning staff roles and responsibilities
   c. Coordination and communication challenges between program staff/partners
   d. Not enough time available to work directly with participants
   e. Challenges maintaining participant motivation and engagement
   f. Participants with episodes of unmanaged symptoms
4. *Challenges obtaining and maintaining participant employment:*
   a. Participant motivation levels
   b. The level of skill, experience, and/or education of participants
   c. Few relevant job openings
   d. Employer stigma or lack of awareness about SMI
   e. Participant symptom management
   f. Difficulties with coworker/supervisor social interactions and/or conflict resolution for some participants
5. *Strategies for maintaining participant engagement in Noble Works:*
   a. Offer incentives for participating in program activities/classes
   b. Maintain regular contact/communication with participants
   c. Invest time in building trust and rapport with participants
   d. Meet clients "where they are at" regarding recovery and employment interests
   e. Support staff commitment and passion for empowering participants
   f. Foster a welcoming and inclusive environment among participants
   g. Highlight the unique opportunities available through Noble Works

GROUP TRAININGS AND SUPPORTS PROVIDED THROUGH NOBLE WORKS

The Noble Works program skill-enhancing and social support classes provided during the Year 1 included:

1. Employment Preparation Classes: 12-week series to help participants with employment preparation
2. Business Development Workshops: 6-week series to help participants with business development
3. Comp TIA A+ Training: Intensive training providing skills and knowledge to help participants prepare for Comp TIA A+ certification (covers technical skills such as installing and configuring computer operating systems, PC hardware and peripherals, mobile device hardware, networking and troubleshooting hardware and network connectivity issues)
4. NAMI SD Tech Café Classes: 7-week series to help participants learn and improve computer usage skills
5. Support Group: 4-week series of support groups to provide participants with a platform to share and discuss challenges as well as success in their employment journey with Noble Works

SUPPORTED EMPLOYMENT PRINCIPLES AND YEAR 1 NOBLE WORKS PRACTICES

Supported Employment is an evidence-based practice recognized by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). Supported Employment has been shown to successfully increase competitive work attainment among persons with SMI, with research indicating that more than half of participants in Supported Employment programs typically obtain competitive employment, compared to about one-quarter of participants in conventional vocational rehabilitation programs.

The Noble Works service delivery approach was intended to incorporate many Supported Employment principles. Table 5 indicates which of the eight key Supported Employment principles were also Noble Works objectives during Year 1, as well as the relevant Noble Works program activities as of 6/30/2016 (based upon program administration review and feedback). In general, Noble Works attempted to operate in a manner consistent with many Supported Employment principles. A primary area of divergence was the separation of vocational and mental health/rehabilitation services. This separation of services was part of the initial Noble Works program design and contract award from the County of San Diego Behavioral Health Services. Additionally, Noble Works staff reviewed referrals to the Noble Works program to determine whether participants appeared to be capable of benefiting from program services, whereas Supported Employment programs only require participant desire to work as the eligibility criteria. This variation was also related to the fact that mental health treatment services were not available directly through the Noble Works program, which increased the perceived need to focus on those determined to be more "ready" to engage in Noble Works program activities.

TABLE 5. SUPPORTED EMPLOYMENT PRINCIPLES AND YEAR 1 NOBLE WORKS PRACTICES

Supported Employment Principles	Year 1 Noble Works Objective	Year 1 Noble Works Activities
1. Focus on competitive employment	Yes	All Noble Work activities were directed towards competitive employment opportunities
2. Program eligibility based on client choice	Partial	Client choice plus referrals were screened for eligibility
3. Integration of mental health and rehabilitation services	No	By contract, Noble Works was designed as a "standalone" vocational program for persons with SMI
4. Attention to participant job preferences	Yes	Participant preferences influenced job search and support activities
5. Personalized governmental benefits counseling	Yes	Public benefits were reviewed with participants
6. Rapid job search	Yes	First contact with employer was reported to typically occur 1-6 months after entering program
7. Systematic job development	Yes	Noble Works initiated outreach to potential employers through community presentations
8. Time-unlimited and individualized support	Yes	Supports were ongoing and tailored to participants

KEY YEAR 1 NOBLE WORKS PROGRAM "LEARNINGS"

1. High staff turnover was a major challenge to Noble Works' implementation and operations.
2. Program "start-up" issues (i.e., hiring, training, establishing facilities, collaborating with partners, developing trainings, etc.) required substantial time commitments during Year 1.
3. Participant satisfaction with their employment situation increased after participating in the Noble Works program.
4. Participant satisfaction with their employment situation was positively associated with a range of other self-reported indicators of their well-being (e.g., self-fulfillment, social connectedness).
5. It was challenging to identify jobs that were of interest to as well as a good skills match for Noble Works participants.
6. Identifying and educating potential employers was difficult, but this objective was perceived as crucial for increasing the pool of known employment opportunities.
7. Noble Works staff were passionate and committed to achieving program objectives.
8. Staff trainings, such as in Supported Employment evidence-based practices, supported the achievement of program objectives.

YEAR 1 PROGRAM CHANGES

There were no changes to the INN-14 Noble Works program that differed substantially from the initial design of the program during the first year of the program (7/1/2015 to 6/30/2016). As is typical during program start-ups, some basic practices and procedures related to recruitment of participants, training and supervision of staff, presentation development and delivery, and coordination with Noble Works partners were adjusted over the course of the first year to better fit the emerging service delivery context of the Noble Works program. However, no changes were made to the fundamental program structure or design. While no major changes were instituted, not all facets of the Noble Works program were implemented during Year 1. Noble Works program components that were not implemented included social enterprise, subsidized apprenticeships with employers, and entrepreneurial business start-ups.

YEAR 1 PROGRAM RECOMMENDATIONS

Recommendations for how to improve the Noble Works program during Year 2 and further increase opportunities for employment for persons with SMI include the following:

1. Maintain full staffing levels and minimize turnover.
2. Increase awareness of Noble Works program to help recruit participants and potential employers (e.g., increase number of community events and/or use of social media).
3. Identify opportunities for maintaining and increasing participant engagement in Noble Works' services (e.g., incentives, frequent "check-ins", etc.).
4. Improve coordination and communication between staff roles and agency partners within Noble Works to present more of a "seamless" program to participants and employers.
5. Assess program operations and streamline activities to maximize the amount of time that staff can work directly with each participant.
6. Implement periodic review/fidelity checks between Noble Works practices and Supported Employment principles.

For additional information about the INN–14 Noble Works program and/or this annual report, please contact:
David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

Presentation Attendee Demographics: INN 14 Noble Works Program

Supplemental Summary

Age	**N**	**%**
0-15 (children/youth)	0	*0%*
16-25 (transition age youth)	75	*19.7%*
26-59 (adult)	177	*46.6%*
60+ (older adults)	86	*22.6%*
Unknown/preferred not to answer	1	*0.3%*
Missing/did not answer	41	*10.8*
TOTAL	**380**	***100%***

Race	N	%
Black/African American	25	*6.6%*
Asian	30	*7.9%*
White	191	*50.3%*
Native American	4	*1.0%*
More than one race	11	*2.9%*
Other	23	*6.0%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	96	*25.3%*
TOTAL	**380**	***100%***

Ethnicity*	**N**	**%**
Hispanic or Latino	63	*16.6%*
Non-Hispanic or Non-Latino	266	*70.0%*
More than one ethnicity	5	*1.3%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	46	*12.1%*
TOTAL	**380**	***100%***

* Presentation attendees completed a demographic form that did not include detailed ethnicities.

Primary Language	**N**	**%**
Unknown/preferred not to answer	0	*0%*
Missing/did not answer[1]	380	*100%*
TOTAL	**380**	***100%***

Presentation attendees completed a demographic form that did not include this item.

Sexual Orientation	N	%
Unknown/preferred not to answer	0	*0%*
Missing/did not answer[1]	380	*100%*
TOTAL	**380**	***100%***

Presentation attendees completed a demographic form that did not include this item.

Disability	N	%
Yes disability	0	*0%*
No disability	0	*0%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	380	*100%*
TOTAL	**380**	***100%***

Presentation attendees completed a demographic form that did not include this item.

Veteran Status	N	%
Yes	0	*0%*
No	0	*0%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	380	*100%*
TOTAL	**380**	***100%***

Presentation attendees completed a demographic form that did not include this item.

Gender: Assigned Sex at Birth	N	*%*
Male	0	*0%*
Female	0	*0%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	380	*100%*
TOTAL	**380**	***100%***

Presentation attendees completed a demographic form that did not include this item.

Gender: Current Gender Identity	N	%
Male	93	*24.5%*
Female	244	*64.2%*
Another gender identity	2	*0.5%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	41	*10.8%*
TOTAL	**380**	***100%***

Participant Demographics: INN 14 Noble Works Program

Supplemental Summary

Age	**N**	**%**
0-15 (children/youth)	0	*0%*
16-25 (transition age youth)	29	*37.7*
26-59 (adult)	45	*58.4*
60+ (older adults)	3	*3.9*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	0	*0%*
TOTAL	**77**	***100%***

Race	N	%
Black/African American	14	*18.2%*
Asian	16	*20.8%*
White	23	*29.9%*
Native American	0	*0%*
More than one race	4	*5.2%*
Other	2	*2.6%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	18	*23.4%*
TOTAL	**77**	***100%***

Ethnicity	N	%	N	%*
Hispanic or Latino	15	*19.5%*		
Central American			1	1.3%
Mexican			10	13.0%
Puerto Rican			1	1.3%
Missing/did not answer			4	5.2%
Non-Hispanic or Non-Latino	56	*72.7%*		
African			4	5.2%
Cambodian			2	2.6%
Chinese			2	2.6%
Filipino			3	3.9%
Japanese			1	1.3%
Korean			3	3.9%
Laotian			1	1.3%
Vietnamese			4	5.2%
Eastern European			1	1.3%
European			3	3.9%
Middle Eastern			1	1.3%
Other			9	11.7%
Missing/did not answer			25	32.5%
More than one ethnicity	3	*3.9%*	3	*3.9%*
Unknown/preferred not to answer	0	*0%*	0	*0%*
Missing/did not answer	3	*3.9%*	3	*3.9%*
TOTAL	**77**	***100%***		

* Totals may add to more than 100% since participants could indicate multiple subethnicities.

Primary Language	N	%
English	66	*85.7%*
Lao	1	*1.3%*
Spanish	4	*5.2%*
Vietnamese	2	*2.6%*
Other	3	*3.9%*
Unknown/preferred not to answer	1	*1.3%*
Missing/did not answer	0	*0%*
TOTAL	**77**	***100%***

Sexual Orientation	N	%
Heterosexual or Straight	62	*80.5%*
Gay or Lesbian	5	*6.5%*
Bisexual	1	*1.3%*
Unknown/preferred not to answer	9	*11.7%*
Missing/did not answer	0	*0%*
TOTAL	**77**	***100%***

Disability	N	%	N	%*	N	%*
Yes disability	50	*64.9%*				
Communication disability			10	*13.0%*		
Difficulty seeing					6	*7.8%*
Difficulty hearing/speaking					5	*6.5%*
Other communication disability					2	*2.6%*
Mental disability			22	*28.6%*		
Learning disability					14	*18.2%*
Developmental disability					3	*3.9%*
Other mental disability					8	*10.4%*
Physical/mobility disability			4	*5.2%*	4	*5.2%*
Chronic health condition			7	*9.1%*	7	*9.1%*
Other disability			18	*23.4%*	18	*23.4%*
No disability	21	*27.3%*	21	*27.3%*	21	*27.3%*
Unknown/preferred not to answer	6	*7.8%*	6	*7.8%*	6	*7.8%*
Missing/did not answer	0	*0%*	0	*0%*	0	*0%*
TOTAL	**77**	**100%**				

* Totals may add to more than 100% since participants could indicate multiple disabilities.

Veteran Status	N	%
Yes	2	*2.6%*
No	73	*94.8%*
Unknown/preferred not to answer	2	*2.6%*
Missing/did not answer	0	*0%*
TOTAL	**77**	**100%**

Gender: Assigned Sex at Birth	N	*%*
Male	42	*54.5%*
Female	35	*45.5%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	0	*0%*
TOTAL	**77**	***100%***

Gender: Current Gender Identity	N	%
Male	42	*54.5%*
Female	33	*42.9%*
Unknown/preferred not to answer	2	*2.6%*
Missing/did not answer	0	*0%*
TOTAL	**77**	***100%***

PEER ASSISTED TRANSITIONS PROGRAM (INNOVATIONS-15)

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

STATUS AS OF 6/30/16

The Peer Assisted Transitions (PAT; INN-15) program is funded through the Innovations (INN) component of the Mental Health Services Act. PAT assists individuals receiving services in acute care settings (e.g., psychiatric hospital or crisis residential) with their transition to the community in a manner that supports long-term health and well-being.

A key component of this program is the use of peer support partners with "lived experience" receiving Behavioral Health Services (BHS). Peer support partners will deliver a 'Welcome Home Basket' of sundries (e.g., toiletries, plants, healthy food, resource information) to the participant to welcome them back to their home. Peer support partners will also help participants bridge the gap between use of acute crisis resources and community-based resources by encouraging regular social outings, thereby reducing isolation and building social relationships. To promote long-term health and wellness, PAT services will be provided for up to 12 months post-discharge from the acute care setting. The extended period of time that PAT services will be available to participants is expected to allow for participants to stabilize in the community, establish additional social relationships, and acquire needed community resources.

EXECUTIVE SUMMARY

The Peer Assisted Transitions (PAT; INN-15) contract began after 6/30/2016, so there were no service provision activities during this current reporting period.

Evaluation results for PAT will be included in the next INN Annual Report cycle.

For additional information about the INN–15 Peer Assisted Transitions program please contact:
David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

URBAN BEATS (INNOVATIONS-16)

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

ANNUAL REPORT: YEAR 1 (7/1/15 - 6/30/16)

The Urban Beats program is funded through the Innovations (INN) component of the Mental Health Services Act and was developed to provide Transitional Age Youth (TAY) with increased access to and knowledge of behavioral health treatment and other wellness services while, as well as reduce mental illness stigma for TAY and for other community members. The primary innovation of this program is the utilization of artistic expression to communicate a recovery-focused message to TAY and develop their artistic skills and self-esteem.

The Urban Beats program consists of a 20-week curriculum that focuses on improving TAY wellness and developing each TAYs desired form of artistic expression. During the second half of the class, Urban Beats staff provide individualized attention to each TAY to help create a performance piece in their preferred form of artistic expression (such as drawing, poetry, song, videography, etc.). At the end of the class, the TAY present their creation in a public performance designed to help educate the community about mental health issues and reduce the stigma associated with mental illness.

EXECUTIVE SUMMARY

The Urban Beats program (INN-16) was designed to provide wellness education and social support to transitional age youth (TAY) with mental health needs through individualized development of TAY artistic expression skills and interests. Artistic expression is expected to reduce stigma in both TAY and the general community through public performances.

- During fiscal year 2015-16, a total of 94 TAY enrolled in the Urban Beats program.
- Urban Beats participants reflected substantial racial/ethnic diversity and diversity of sexual orientation. The majority indicated they were seeking employment.
- Urban Beats participants had fairly optimistic views of their future and their ability to make positive life changes, but many had concerns about their ability to handle stress, having enough income to meet needs, and the quality of their social relationships and health.
- While the small number of participants with follow-up data (n=25) limited definitive conclusions, preliminary findings suggested positive improvements in key outcome areas targeted by the Urban Beats program, including the increased ability of TAY to manage stress, have sufficient income, be involved in meaningful activities, and have higher satisfaction with their social relationships.
- Almost 80% reported being satisfied with the Urban Beats program, with the majority indicating that as a result of the program they knew better where to get help, were more comfortable seeking help, could more effectively deal with problems, and were less bothered by symptoms.
- Preliminary 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 admissions, emergency psychiatric visits).
- Key qualitative focus group findings showed that: 1) youth indicated satisfaction and positive outcomes from Urban Beats activities, classes, and performances, underscoring its value as a strengths-based program, 2) outreach and recruitment activities evolved as staff worked to expand the program, moving away from traditional mental health venues and into schools and other settings, and 3) each successive Urban Beats cohort had less prior exposure to mental health and wellness issues.

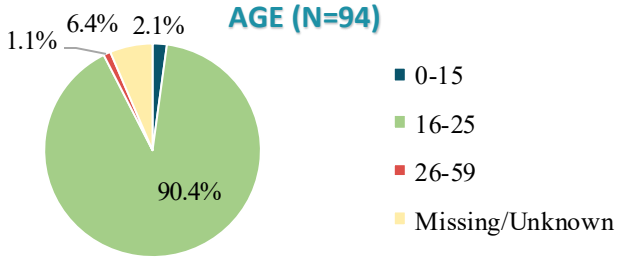
RECOMMENDATIONS

Primary recommendations for service provision improvements include: 1) identify additional community partners, particularly schools, to facilitate TAY recruitment, 2) provide more training and team building opportunities for staff, 3) develop strategies to increase the number of community performances and performance attendance, 4) use Urban Beats "graduates" to help recruit new TAY and mentor future Urban Beats classes, 5) employ social media strategies to advance program goals (e.g., TAY recruitment, retention, and community outreach), 6) continue to assess and update Urban Beats curriculum to promote ongoing good fit with target TAY participants, 7) reexamine evaluation approach to identify optimal balance between data collection needs and burden on participants and staff.

URBAN BEATS PARTICIPANT DEMOGRAPHICS

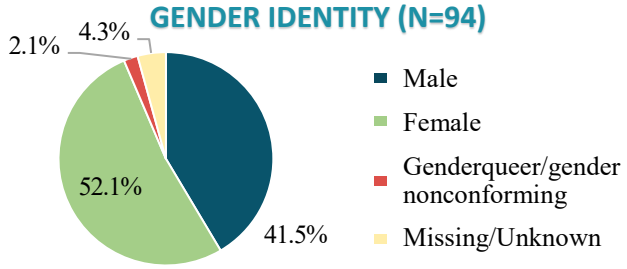
The following demographic data were collected from a participant self-report survey administered at the start of Urban Beats.

AGE (N=94)



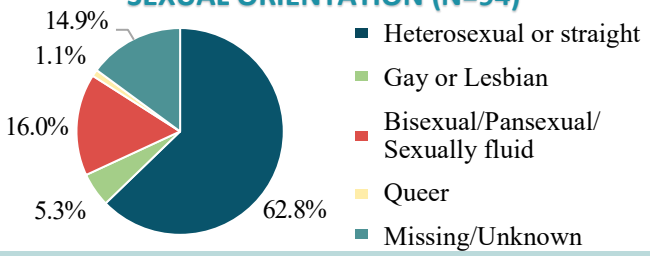
The majority (90%) of participants were between the ages of 16 and 25.

GENDER IDENTITY (N=94)



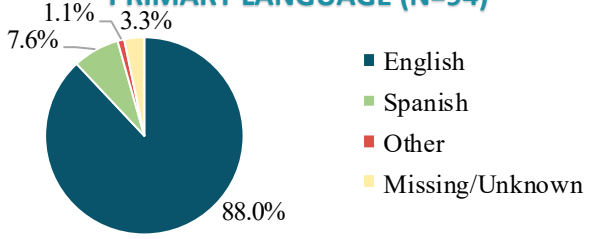
Forty-two percent of participants were male, and 52% of participants were female.

SEXUAL ORIENTATION (N=94)



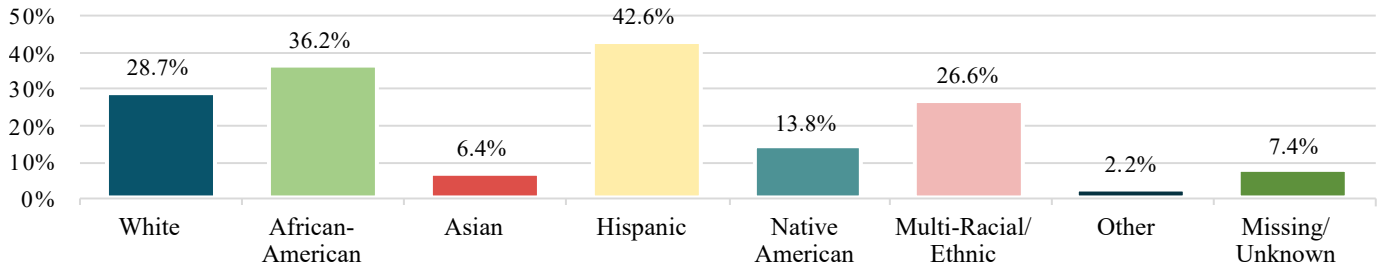
Over half (63%) of participants were heterosexual or straight, and 16% identified as bisexual, pansexual, or sexually fluid.

PRIMARY LANGUAGE (N=94)



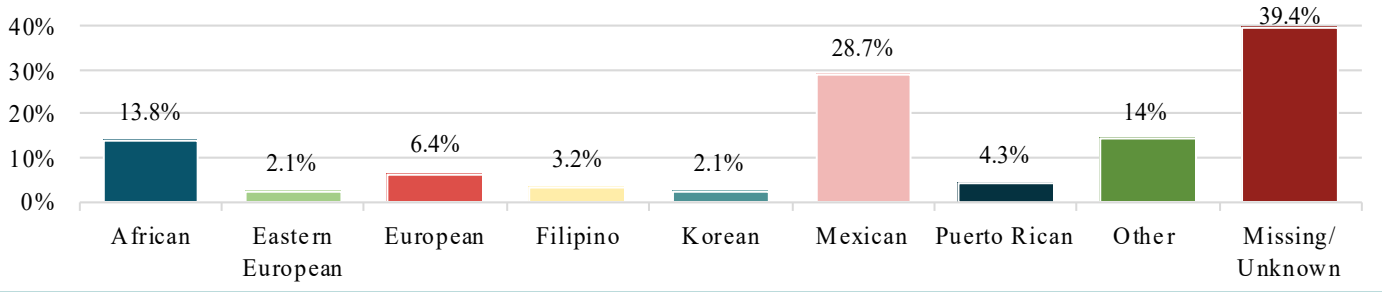
The majority (88%) of participants spoke English as their primary language.

RACE/ETHNICITY (N=94)



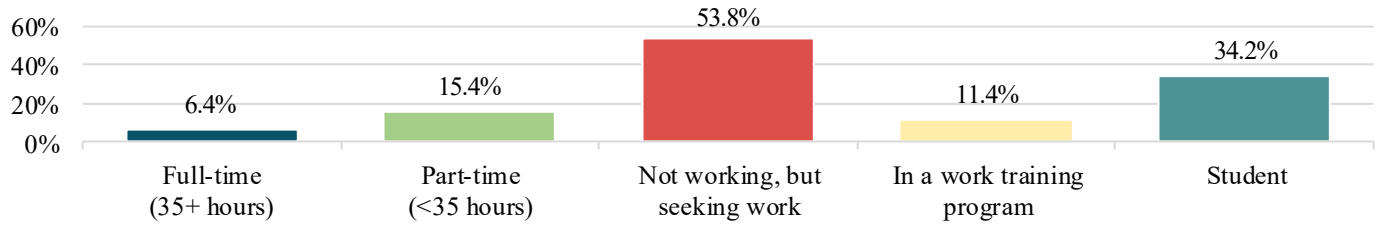
Forty-three percent of participants identified as Hispanic, 36% were African-American, 29% were White, and 27% were multi-racial/ethnic. Totals may exceed 100% as participants were able to indicate more than one race/ethnicity.

ETHNIC BACKGROUND (N=94)



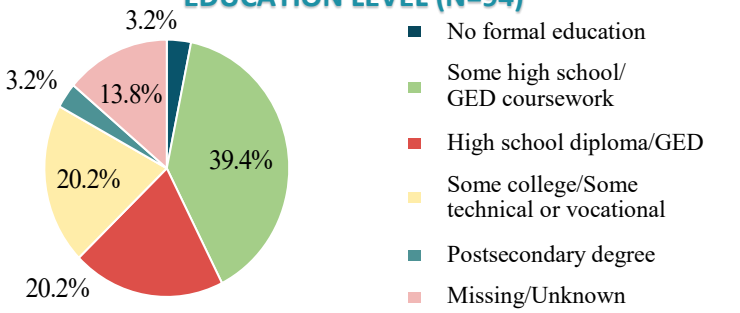
Twenty-nine percent of participants identified as being of Mexican origin, and 14% identified as being of African origin. Total may exceed 100% as participants were able to indicate more than one ethnic background.

EMPLOYMENT STATUS (N=94)



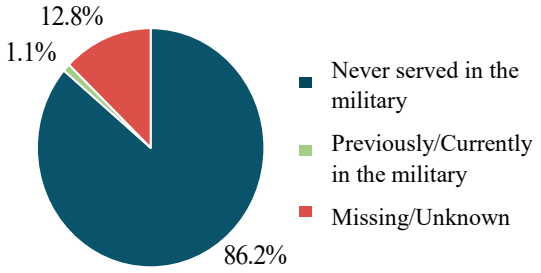
The majority (53.8%) of participants indicated they were not working but seeking work, and approximately 20% were working either full-time (6.4%) or part-time (15.4%). Almost half were in an educational program (34.2% in school and 11.4 in a work training program). Totals may exceed 100% as participants could select more than one employment status category.

EDUCATION LEVEL (N=94)



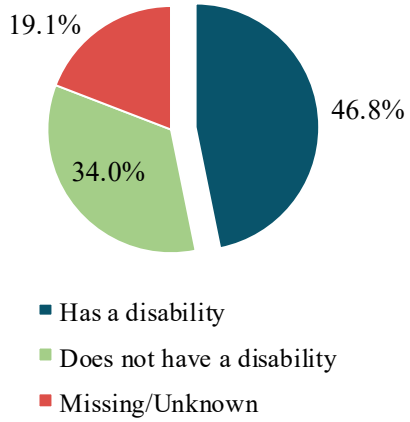
Thirty-nine percent had some high school/GED coursework, 20% had a high school diploma or GED, and 20% had completed some college.

MILITARY STATUS (N=94)



The majority (86%) of participants had never served in the military.

DISABILITY[1] STATUS (N=94)



Forty-seven percent of participants indicated having some type of non-SMI disability.

TYPE OF DISABILITY (N=94)

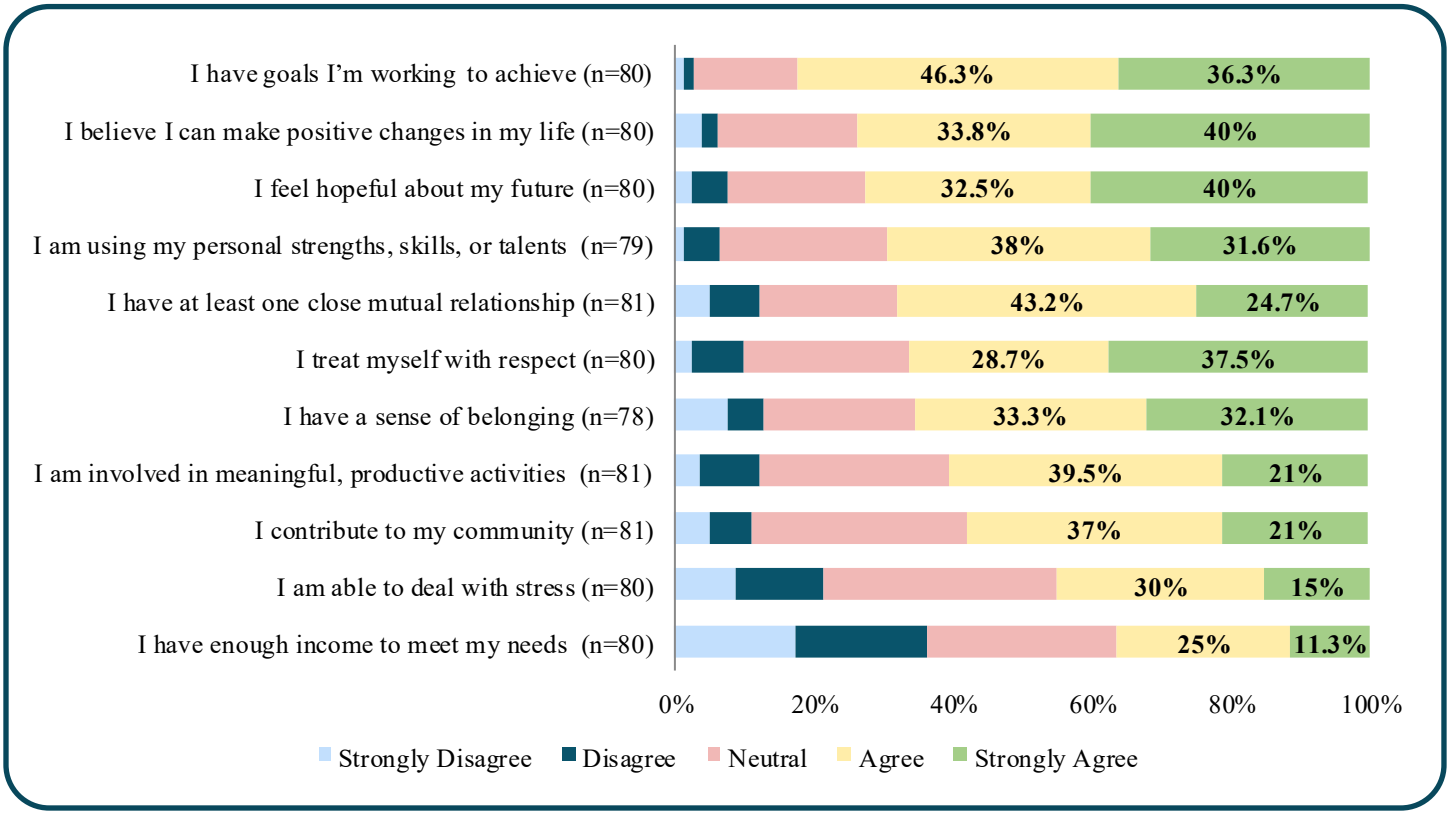
Type	n	%
Difficulty Seeing	17	18.1
Communication	4	4.3
Learning	21	22.3
Other Mental/Developmental	10	10.6
Physical	3	3.2
Other	10	10.7

This table describes the type of disability indicated by participants that had a disability, as a percentage of the total population. The high percentage of participants indicating difficulty seeing appears to be related to participants who needed some form of vision correction, such as glasses or contacts. Totals may exceed 100% as participants could indicate more than one type of disability.

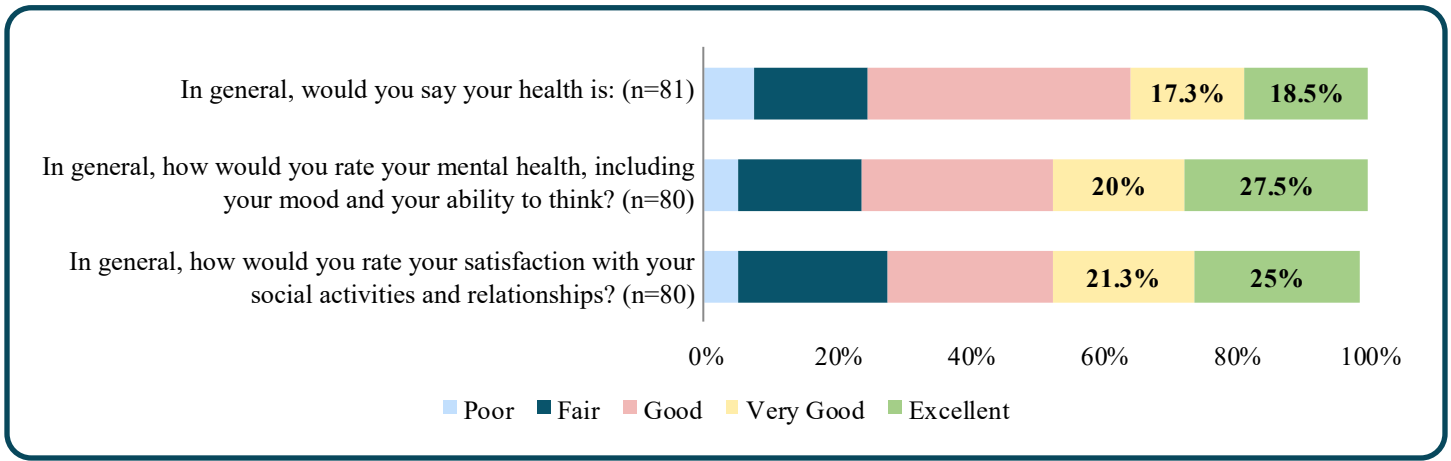
[1] *A disability was defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness (SMI).*

URBAN BEATS PARTICIPANT BELIEFS

Over the course of fiscal year 2015-16, Urban Beats had two cohorts of participants that completed the Urban Beats curriculum. At the start of each Urban Beats round, participants were asked to complete a baseline Wellness Survey, the results of which are shown in the following charts. Part of the Wellness Survey included select items from the Recovery Markers Questionnaire (RMQ), and participant responses are listed in the chart below in order of highest to lowest percentage of agreement (i.e., indicated Agree or Strongly Agree). The most commonly endorsed statements (i.e., at least 70% agreed or strongly agreed) focused on participants' beliefs about their self-efficacy and optimism regarding their future. Participants appeared to be less enthusiastic about their stress management capabilities and having sufficient income. Only 15.0% strongly agreed that they were "able to deal with stress", and 11.3% strongly agreed that they had "enough income to meet [their] needs." These findings suggest that the Urban Beats program is enrolling TAY who are generally goal oriented and optimistic about what they can accomplish, but who are also concerned about their ability to handle stress and having sufficient financial resources—two key issues addressed by the Urban Beats program.

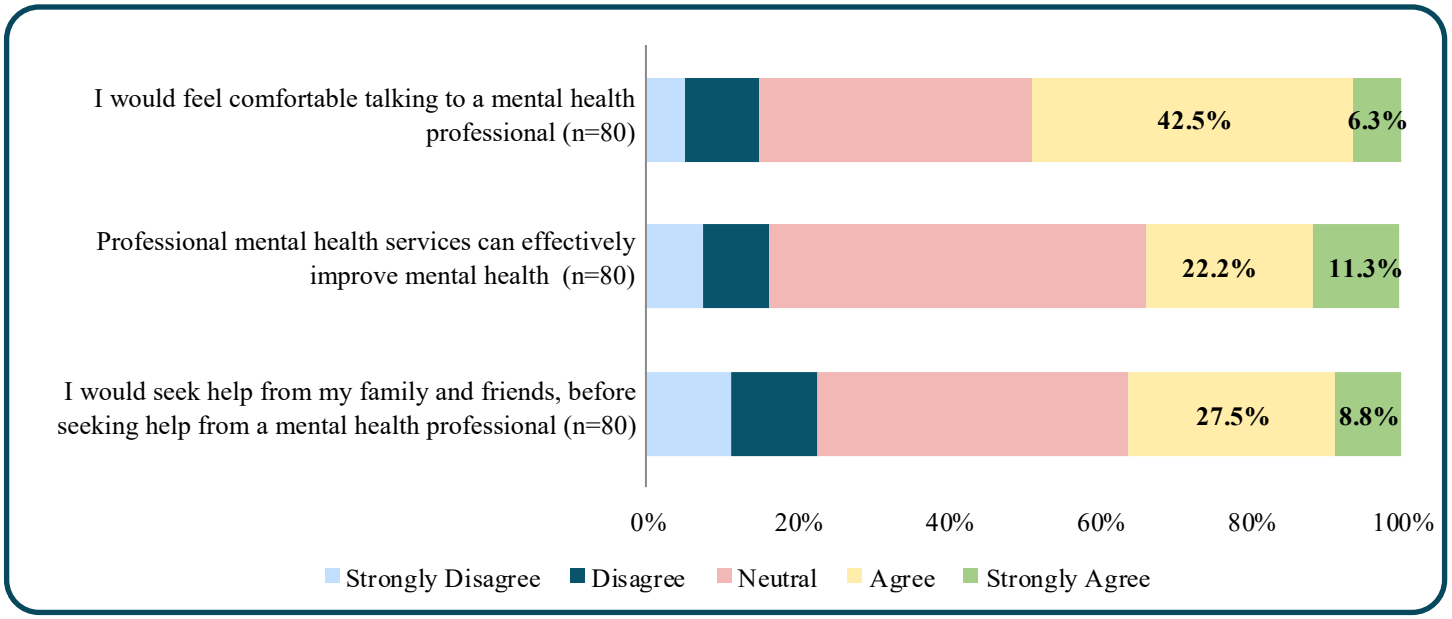


The baseline Wellness Survey also inquired about the quality of health, mental health, and satisfaction with social activities and relationships. As shown in the chart below, a substantial number of the Urban Beat participants had health and mental health concerns—only 18.5% thought their overall health was excellent, and 27.5% thought their mental health was excellent. Almost 30% (28.8%) also rated their satisfaction with their social activities and relationships as fair or poor. These findings highlight the importance of focusing on physical and mental health and social relationships within the Urban Beats program.



URBAN BEATS PARTICIPANT ATTITUDES ABOUT MENTAL HEALTH SERVICES

Lastly, the baseline Wellness Survey asked Urban Beats participants about their attitudes about mental health services. Almost half (48.8%) of the Urban Beats participants agreed or strongly agreed that they would "feel comfortable talking to a mental health professional" (although only 6.3% strongly agreed). However, only 33.5% agreed or strongly agreed that "professional mental health services can effectively improve mental health." These findings indicate that many Urban Beats participants have negative or ambivalent perceptions of professional mental health services and may not feel comfortable with mental health professionals. The Urban Beats program sought to address these concerns through psychoeducation and promoting engagement with professional mental health services when needed.



KEY EVALUATION FINDINGS: FOLLOW-UP

CHANGES IN URBAN BEATS PARTICIPANT BELIEFS

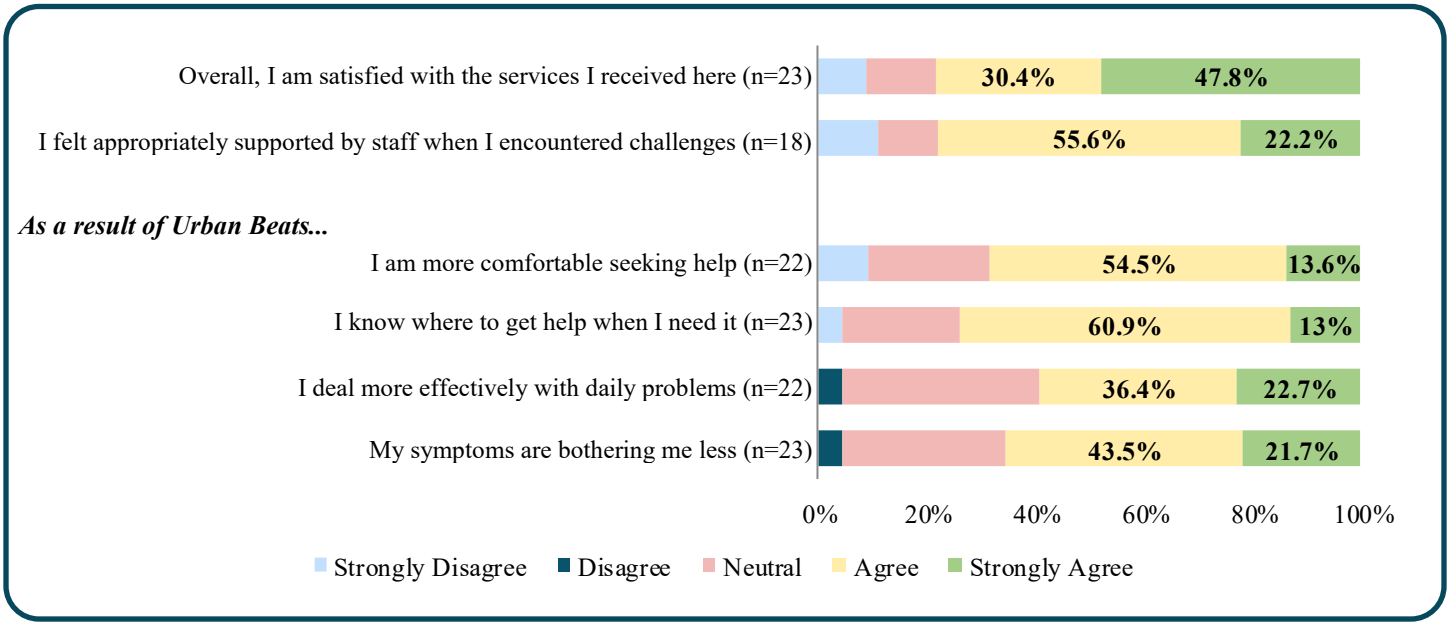
A 6-month follow-up Wellness Survey was administered to Urban Beats program participants; however, there were no statistically significant differences between baseline and the 6-week follow-up responses. A contributing factor was the small number of participants who responded to both baseline and follow-up surveys (n=25). However, several items exhibited potentially meaningful changes that will continue to be monitored in future reporting periods as the number of Urban Beats participants with completed follow-up surveys increases. As shown in Table 1 below, indicators related to satisfaction with social relationships, sense of involvement in meaningful activities, having sufficient income, and dealing with stress all improved at follow-up. Each of these represents different issues that the Urban Beats programs specifically sought to address. Of note, participants indicated slightly lower ratings of their mental health at follow-up. One potential explanation is that by the 6-week follow-up, Urban Beats participants might have felt more open, honest, and aware of their mental health.

TABLE 1. QUANTITATIVE ASSESSMENT OF URBAN BEATS PARTICIPANT CHANGES

	Change in Mean Score
In general, how would you rate your mental health, including your mood and your ability to think?	Worsened at follow-up
In general, how would you rate your satisfaction with your social activities and relationships?	Improved at follow-up
I am involved in meaningful, productive activities.	Improved at follow-up
I have enough income to meet my needs.	Improved at follow-up
I am able to deal with stress.	Improved at follow-up

URBAN BEATS OUTCOMES

As shown in the charts below, over three-quarters (78.2%) of Urban Beats participants with follow-up Wellness Survey data indicated they were satisfied with the Urban Beats program (47.8% strongly agreed). A similar percentage (77.8%) thought they were "appropriately supported by staff when [they] encountered challenges." The majority indicated that as a result of participating in the Urban Beats program, they felt "more comfortable seeking help" (68.0%), knew "where to get help" (73.9%), dealt "more effectively with daily problems (59.1%), and were less bothered by symptoms (65.2%).



BEHAVIORAL HEALTH SERVICE UTILIZATION PATTERNS OF URBAN BEATS PARTICIPANTS

The utilization of San Diego County Behavioral Health Services by Urban Beats participants was examined at several time points, both before and after starting participation in the Urban Beats program. As shown in Table 2, a little over one-quarter of the 94 Urban Beats participants had at least one SDCBHS outpatient or Assertive Community Treatment (ACT) visit within the 90 days prior to starting Urban Beats (27.7% and 24.5%, respectively). The participation rates for these services were essentially the same at 90 days after starting the Urban Beats program. A similar pattern of no substantial change in outpatient and ACT participation rates was found when examining utilization 180 days both before and after starting Urban Beats. These analyses only include the subset of participants (n=55) who started the Urban Beats program at least 180 days prior to the end of the reporting period (6/30/2016).

While acute/crisis care services of Psychiatric Emergency Response Teams (PERT), Emergency Psychiatric Units (EPU), and inpatient hospitalizations were lower frequency events overall, there was some evidence of reduced utilization of these services after starting the Urban Beats program. This trend appeared to be particularly evident when examining the subset of participants observed for 180 days before and after starting Urban Beats. Given the relatively small sample size (n=55) and the low frequencies of the acute care services, these findings should be interpreted with caution. Service utilization patterns will continue to be examined in future reporting periods to determine if these trends persist with larger sample sizes.

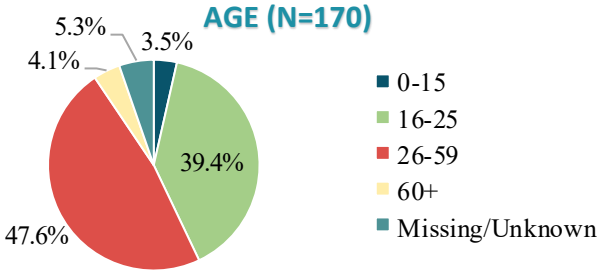
TABLE 2. COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICE UTILIZATION BEFORE/AFTER URBAN BEATS PARTICIPATION

At least one...	90 Days Before Start Urban Beats (n=94)	90 Days After Start Urban Beats (n=94)	180 Days Before Start Urban Beats (n=55)	180 Days After Start Urban Beats (n=55)
Outpatient Visit	27.7%	24.5%	38.2%	36.4%
ACT Visit	28.7%	28.7%	34.5%	32.7%
PERT	1.1%	3.2%	5.5%	1.8%
EPU	6.4%	0%	10.9%	3.6%
Inpatient Admit	4.3%	3.2%	16.4%	3.6%

COMMUNITY PERFORMANCE ATTENDEE DEMOGRAPHICS

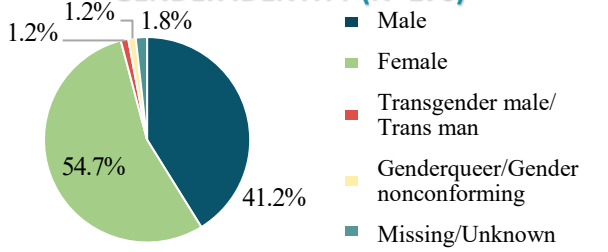
The following demographic data were collected from an audience self-report survey administered at the community performances.

AGE (N=170)



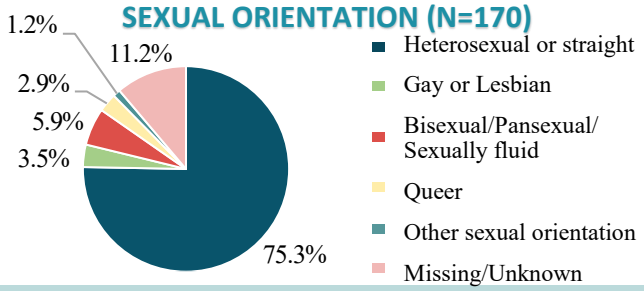
Thirty-nine percent of attendees were between the ages of 16 and 25, and 48% were between 26 and 59.

GENDER IDENTITY (N=170)



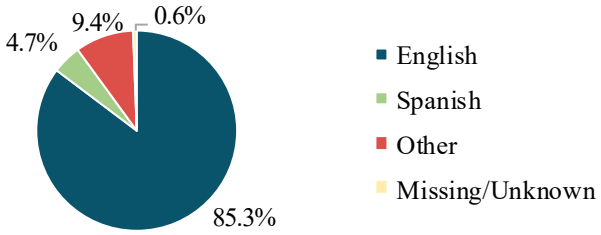
Forty-one percent of attendees were male, and 55% of attendees were female.

SEXUAL ORIENTATION (N=170)



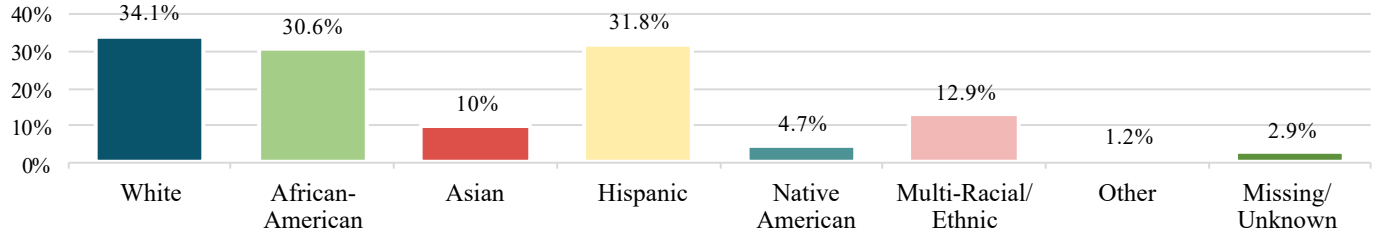
Three-quarters (75%) of participants were heterosexual or straight.

PRIMARY LANGUAGE (N=170)



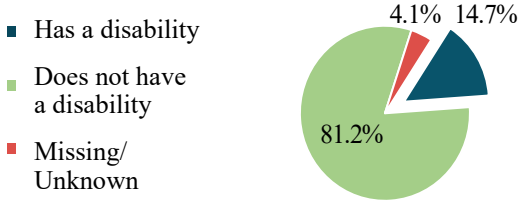
The majority (85%) of participants spoke English as their primary language.

RACE/ETHNICITY (N=170)



About one-third (34%) of attendees identified as White, one-third (31%) as African-American, and one-third (32%) as Hispanic. Totals may exceed 100% as attendees could indicate more than one race/ethnicity.

DISABILITY[1] STATUS (N=170)



Fifteen percent of attendees had some type of non-SMI disability.

The majority (91%) of attendees had never served in the military.

TYPE OF DISABILITY (N=170)

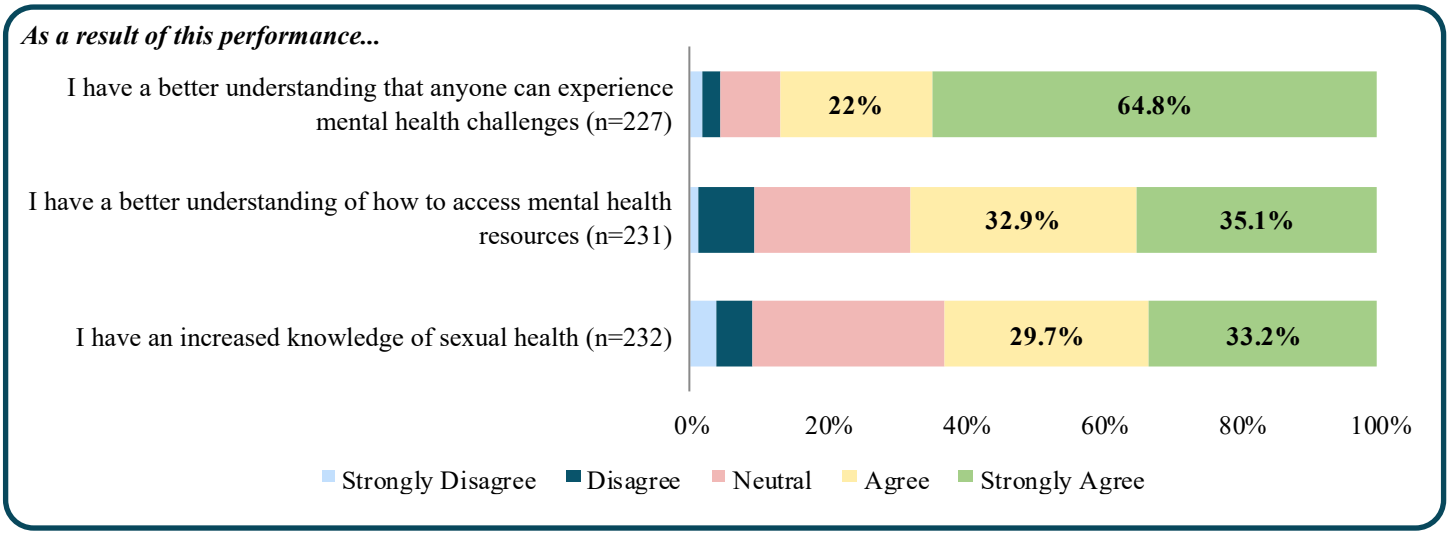
Type	n	%
Communication	11	6.5
Mental (e.g., learning, developmental)	12	7.1
Physical	1	0.6
Chronic Health	0	0.0
Other	4	2.4

The table above describes the types of disabilities these attendees had. Totals may exceed 100% as attendees could indicate more than one type of disability.

[1] *A disability was 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 (SMI).*

COMMUNITY PERFORMANCE OUTCOMES

A total of 234 persons who attended the community performances completed a brief "outcomes" survey. Participants were asked to indicate the extent to which they agreed or disagreed with each statement on a 5-point scale. As shown in the chart below, 64.8% of all respondents strongly agreed and 22.0% agreed that because of the performance, they had a better understanding that anyone can experience mental health challenges. This was the most prominent outcome from the post-performance survey data, although significant majorities also agreed or strongly agreed that they had a better understanding of how to access mental health resources (68.0%) and an increased knowledge of sexual health (62.9%).



The response patterns between TAY (n=100) and non-TAY (n=134) that attended the performance were nearly identical, except that a higher percentage of non-TAY respondents indicated they strongly agreed that they "had a better understanding that anyone can experience mental health challenges" (69.8% compared to 58.2%). This may suggest that while a substantial majority of both TAY and non-TAY respondents better understood mental health challenges as a result of the community performance, community performances may be particularly effective at communicating messages of empathy and stigma reduction related to mental health issues for non-TAY community members.

URBAN BEATS YOUTH AND STAFF QUALITATIVE FOCUS GROUP FINDINGS

Focus groups were held with Urban Beats youth and staff periodically throughout the year. Per the evaluation plan described in the original contract, the focus groups were designed to "*examine whether UB is perceived as adopting a **strengths-based approach** and document their perspectives on how programs like UB can **improve youth outreach to and engagement of underserved TAY populations**.*"

Six focus groups were held throughout the year, including two with Youth Service Partner (YSP) staff and four with Urban Beats youth:

December 2015, halfway through the first round of Urban Beats: two focus groups with youth and one focus group with staff, centering on the experience of Urban Beats so far.

March 2016, after the final performance of the first round of Urban Beats: one focus group with youth, centering on their final performance.

July/August 2016, after the final performance of the second round of Urban Beats: one focus group with youth and one focus group with staff, centering on their final performance. A few youth at the focus group were involved in both the first and second rounds of Urban Beats.

Youth focus groups typically included between four and eight Urban Beats members, while staff focus groups included between three and five YSPs. Question guides that covered relevant topic areas for each time point were developed for each focus group and asked similar questions of both youth and staff. The focus groups included discussions of the successes and challenges of developing Urban Beats' content and structure; outreach, recruitment, and retention in the program; youth satisfaction and perceived outcomes; using a strengths-based approach; and the final performances.

DIFFERENCES BETWEEN THE FIRST AND SECOND COHORTS OF URBAN BEATS

It is important to note that as Urban Beats grew and conducted more widespread outreach and recruitment over the year, the profile of each successive cohort changed. Most of the first cohort of Urban Beats youth were already engaged with the Oasis Clubhouse (Pathways) or TAY Academy (San Diego Youth Services, SDYS) before joining Urban Beats. These youth were already familiar with mental health issues, terminology, and stigma, and most had been diagnosed with a mental illness. Those who participated in the second round of Urban Beats included both youth who had also participated in the first round, as well as new youth, who had been less exposed to mental health programs and had less familiarity with terms, diagnoses, and stigma.

Consequently, YSPs described that messages about stigma resonated with the youth in the first round of Urban Beats, whereas messages about trauma resonated more with the youth in the second round. YSPs developed different activities and curricula for each round accordingly.

At both staff focus groups, YSPs expressed some concern at the rapid pace of Urban Beats' development and implementation. While they had spent time reflecting on their practices and adapting the program accordingly during the course of the program, the YSPs felt that a short break in the programming would help them reflect and reorient to improve the program.

YOUTH SATISFACTION, STRENGTHS-BASED APPROACH, AND PERCEIVED OUTCOMES

The way youth and staff described their experiences with Urban Beats reflected a strengths-based approach. In all youth focus groups, youth were very satisfied with the program, understood and supported the goals of Urban Beats, and were able to link Urban Beats activities to perceived personal benefits (i.e., outcomes).

Youth focus group participants felt they had improved in their creative skills, were better able to communicate with others (particularly regarding mental health stigma), were more confident and comfortable, and had also learned leadership and self-discovery skills. Youth also indicated that these skills were laying the groundwork for larger ambitions, such as identifying what careers they might want to pursue and giving them the skills and confidence to achieve their goals. This sentiment was echoed in the YSP focus groups. A few youth, especially those who had been in both rounds of Urban Beats, reported that either they themselves or others from their cohort had found jobs in entertainment/the arts or in mental health as peers.

Across the focus groups, youth spoke very positively about their interactions with YSPs, indicating that the support and recognition they received from staff was valued by them, made them feel more confident, and helped them try new things (e.g. different types of artistic expression, public speaking). Staff indicated that they felt their techniques, such as active listening, worked well with youth, and that they were able to relate well to youth given their own personal experiences. YSPs described having a role similar to being a peer mentor but also had education/work experience in the field of mental health or social work, which they believed helped them earn the respect of the Urban Beats youth.

PERFORMANCES

At the time of the focus groups, youth were either planning or had recently completed their final performance. The youth discussed attending other open-mic nights or similar events in the community where they could practice and become more comfortable performing for an audience, which they found enjoyable and helpful. Several youths indicated that they had started going to open-mic nights on their own. Some youth talked about feeling nervous and unprepared for the final performances but felt relieved and accomplished afterwards.

Urban Beats youth enjoyed having a substantial role in planning the second final performance, such as creating the stage decorations. Held in different local venues, the second performance was not as well attended as the first final performance; youth indicated that this may have been due to parking issues or less collaboration from other organizations to bring in more attendees. Youth suggested promoting the events at other similar performances in the community.

OUTREACH, RECRUITMENT, AND RETENTION IN URBAN BEATS

YSPs indicated that although efforts were made to shorten the evaluation survey and make it more youth-friendly, the evaluation survey's resemblance to a formal mental health treatment assessment still alienated some youth, affecting early program retention rates negatively. Youth stated that a good approach would be to have youth recruit other youth and conduct outreach through a variety of venues and platforms, such as social media, local performances, and schools. In the final focus group with youth, those who had been in both cohorts of Urban Beats mentioned that they were actively participating in outreach and recruitment events, such as the Four Corners of Life event held in the Southeast San Diego community. Staff were especially interested in conducting more comprehensive outreach with local community organizations, but felt that they had little time to do so while running overlapping rounds of Urban Beats. Staff also felt that they had little authority to make real connections or promises to community groups, as this needed to come from leadership.

URBAN BEATS PROGRAM ANNUAL STAFF FEEDBACK SURVEY

At the end of the first year of providing the INN Urban Beats program, administrative and provider staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the Urban Beats program. There were nine respondents from the 10 persons invited to participate in the survey, for a response rate of 90.0%. For the open-ended survey questions, at least two evaluators reviewed and coded the responses, and any discrepancies were discussed to arrive at a consensus on the key response themes.

1. *The major program goals identified by Urban Beats staff:*
    a. Engage TAY through artistic expression
    b. Facilitate mental health and general wellness education
    c. Reduce mental health stigma
    d. Conduct community outreach and education
    e. Increase awareness of and connection to mental health services
2. *Factors that helped the Urban Beats program achieve goals:*
    a. The unique and wide set of Urban Beats staff's skills and passions related to artistic talents, youth engagement, and leadership
    b. Urban Beats staff having "lived experience" with mental health services
    c. Opportunities for community performances benefit both TAY and community members
    d. Close collaboration between Urban Beat staff and participants, resulting in individualized support
    e. Developing partnerships with other community organizations
    f. Creation of a positive, safe, and inclusive program climate
    g. Providing TAY with a voice in program decision-making
3. *Relationship between public performances and achievement of overall program goals:*
    a. Provided a specific event to center Urban Beats educational activities around
    b. Encouraged TAY to express themselves publicly and build self-confidence
    c. Functioned as "platform" for communicating a mental health stigma reduction message to the community
    d. Increased awareness of the Urban Beats program to facilitate TAY recruitment and other organizational partnerships
    e. Required youth to develop other skills needed to create, plan, and execute the event, in addition to their artistic talents
4. *How Urban Beats helped TAY engage with needed mental health services:*
    a. Created a "safe space" for open and non-judgmental communication about mental health services
    b. Provided direct linkages/referrals to outpatient and other services
5. *Role of Urban Beats to help TAY reduce mental illness stigma among themselves and in the community:*
    a. Allowing TAY to communicate their stories to the community in a creative and empowering way
    b. Starting the conversation among the community regarding mental health stigma through public performances
    c. Providing an opportunity for TAY hear stories from other TAY in a safe and non-judgmental environment
    d. Facilitating development of peer supports over an extended period of time through program participation

KEY YEAR 1 URBAN BEATS PROGRAM "LEARNINGS"

1. An arts-based curriculum was an effective approach to engage TAY in a behavioral health-oriented outreach and support program, particularly for racial/ethnic and sexual orientation minorities who may be underserved in more traditional service settings.
2. Including a public performance component of the Urban Beats program was vital for achieving program objectives.
3. The personal "lived experience" of Urban Beats' staff with receiving mental health services facilitated connections with TAY and discussions about accessing needed services.
4. The length of the Urban Beats program (i.e., 20 weeks) created some difficulties retaining participants throughout program, but the extended amount of time that the TAY worked with each other and Urban Beats staff also encouraged the development of mentor- and peer-support relationships.
5. It was important to adapt the Urban Beats curriculum to accommodate and recruit a broader population of youth (e.g., initially focus on trauma rather than stigma for youth with less direct exposure to mental health issues and services).
6. Short-term Urban Beats outcomes, such as increased communication, leadership, and self-discovery skills, may be "stepping stones" to bigger, longer-term outcomes related to education, employment, and mental health and wellness management.
7. It is essential to recruit and retain creative, talented, and passionate Urban Beats staff.
8. Urban Beats "graduates" who assisted with subsequent classes took on more responsibilities for outreach and performance planning and functioned as peer mentors for incoming cohorts.

YEAR 1 PROGRAM CHANGES

There were no changes to the INN-16 Urban Beats program that differed substantially from the initial program design during the first year of service provision (7/1/2015 to 6/30/2016). As is typical during program start-ups, basic practices and procedures were adjusted and refined over the course of the first year to better fit the service delivery context and the emerging set of community partnerships. These changes were related to curriculum development and delivery, TAY recruitment, and the community performance. However, no fundamental or program-wide changes were made.

YEAR 1 PROGRAM RECOMMENDATIONS

Recommendations for how to improve the Urban Beats program and support the achievement of program objectives include the following:

1. Identify additional community partners, particularly schools, to facilitate TAY recruitment.
2. Provide more training and team building opportunities for staff.
3. Develop strategies to increase number of community performances and performance attendance.
4. Expand use of Urban Beats "graduates" to help recruit new TAY and act as mentors in future Urban Beats classes.
5. Incorporate more strategic use of social media to advance program goals (e.g., TAY recruitment, retention, education, and community outreach).
6. Continue to purposefully assess, revise, and implement Urban Beats curriculum to promote ongoing fit with target participants.
7. Re-examine evaluation approach to identify optimal balance between data collection needs and burden on participants and staff.

For additional information about the INN–16 Urban Beats program and/or annual report, send your inquiry to:
David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

Performance Attendee Demographics: INN 16 Urban Beats Program

Supplemental Summary

Age	N	%
0-15 (children/youth)	6	*3.5%*
16-25 (transition age youth)	67	*39.4%*
26-59 (adult)	81	*47.6%*
60+ (older adults)	7	*4.1%*
Unknown/preferred not to answer	9	*5.3%*
Missing/did not answer	0	*0%*
TOTAL	**170**	***100%***

Race	N	%
Black/African American	42	*24.7%*
Asian	14	*8.2%*
White	45	*26.5%*
Native American	4	*2.4%*
Pacific Islander	14	*8.2%*
More than one race	1	*0.6%*
Other	1	*0.6%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	49	*28.8%*
TOTAL	**170**	***100%***

Ethnicity	N	%	N	%*
Hispanic or Latino	44	*25.9%*		
Mexican			26	*15.3%*
Puerto Rican			10	*5.9%*
Other			4	*2.4%*
South American			1	*0.6%*
Missing/did not answer			8	*4.7%*
Non-Hispanic or Non-Latino	111	*65.3%*		
African			13	*7.6%*
Chinese			4	*2.4%*
Filipino			7	*4.1%*
Vietnamese			3	*1.8%*
European			6	*3.5%*
Other			15	*9.5%*
Missing/did not answer			68	*40.0%*
More than one ethnicity	10	*5.9%*	10	*5.9%*
Unknown/preferred not to answer	0	*0%*	0	*0%*
Missing/did not answer	5	*2.9%*	5	*2.9%*
TOTAL	**170**	***100%***		

* Totals may add to more than 100% since participants could indicate multiple subethnicities.

Primary Language	N	%
American Sign Language	7	*4.1%*
Arabic	1	*0.6%*
Armenian	1	*0.6%*
English	145	*85.3%*
Portuguese	1	*0.6%*
Spanish	8	*4.7%*
Vietnamese	3	*1.8%*
Other	3	*1.8%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	1	*0.6%*
TOTAL	**170**	***100%***

Sexual Orientation	N	%
Heterosexual or Straight	128	*75.3%*
Gay or Lesbian	6	*3.5%*
Bisexual	10	*5.9%*
Queer	5	*2.9%*
Another sexual orientation	2	*1.2%*
Unknown/preferred not to answer	16	*9.4%*
Missing/did not answer	3	*1.8%*
TOTAL	**170**	***100%***

Disability	N	%	N	%*	N	%*
Yes disability	25	*14.7%*				
Communication disability			11	*6.5%*		
Difficulty seeing					7	*4.1%*
Difficulty hearing/speaking					4	*2.4%*
Mental disability			12	*7.1%*		
Learning disability					8	*4.7%*
Developmental disability					1	*0.6%*
Other mental disability					3	*1.8%*
Physical/mobility disability			1	*0.6%*	1	*0.6%*
Chronic health condition			0	*0%*	0	*0%*
Other disability			4	*2.4%*	4	*2.4%*
No disability	138	*81.2%*	138	*81.2%*	138	*81.2%*
Unknown/preferred not to answer	7	*4.1%*	7	*4.1%*	7	*4.1%*
Missing/did not answer	0	*0%*	0	*0%*	0	*0%*
TOTAL	**170**	***100%***				

* Totals may add to more than 100% since participants could indicate multiple disabilities.

Veteran Status	N	%
Yes	13	*7.7%*
No	149	*87.6%*
Unknown/preferred not to answer	8	*2.9%*
Missing/did not answer	0	*0%*
TOTAL	**170**	***100%***

Gender: Assigned Sex at Birth	N	*%*
Male	68	*40.0%*
Female	97	*57.1%*
Unknown/preferred not to answer	2	*1.2%*
Missing/did not answer	3	*1.8%*
TOTAL	**170**	***100%***

Gender: Current Gender Identity	N	%
Male	70	*41.2%*
Female	93	*54.6%*
Transgender	2	*1.2%*
Genderqueer	2	*1.2%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	3	*1.8%*
TOTAL	**170**	***100%***

Participant Demographics: INN 16 Urban Beats Program

Supplemental Summary

Age	N	%
0-15 (children/youth)	2	*2.1%*
16-25 (transition age youth)	85	*90.4%*
26-59 (adult)	1	*1.1%*
60+ (older adults)	0	*0%*
Unknown/preferred not to answer	6	*6.4%*
Missing/did not answer	0	*0%*
TOTAL	**94**	***100%***

Race	N	%
Black/African American	24	*25.5%*
Asian	2	*2.1%*
White	17	*18.1%*
Native American	4	*4.3%*
More than one race	15	*16.0%*
Other	0	*0%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	32	*34.0%*
TOTAL	**94**	***100%***

Ethnicity	N	%	N	%*
Hispanic or Latino	25	*26.6%*		
Mexican			23	*24.5%*
Puerto Rican			2	*2.1%*
Other			3	*3.2%*
Missing/did not answer			6	*6.4%*
Non-Hispanic or Non-Latino	47	*50.0%*	47	*50.0%*
African			11	*11.7%*
Asian Indian/South Asian			1	*1.1%*
Filipino			2	*2.1%*
Korean			1	*1.1%*
European			4	*4.3%*
Other			7	*7.4%*
Missing/did not answer			24	*25.5%*
More than one ethnicity	15	*16.0%*	7	*7.4%*
Unknown/preferred not to answer	0	*0%*	0	*0%*
Missing/did not answer	7	*7.4%*	7	*7.4%*
TOTAL	**94**	***100%***		

* Totals may add to more than 100% since participants could indicate multiple subethnicities.

Primary Language	N	%
American Sign Language	1	*1.1%*
Armenian	1	*1.1%*
English	81	*86.2%*
Spanish	7	*7.4%*
Other	1	*1.1%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	3	*3.2%*
TOTAL	**94**	***100%***

Sexual Orientation	N	%
Heterosexual or Straight	59	*62.8*
Gay or Lesbian	5	*5.3*
Bisexual	15	*16.0*
Queer	1	*1.1*
Unknown/preferred not to answer	11	*11.7*
Missing/did not answer	3	*3.2*
TOTAL	**94**	***100%***

Disability	N	%	N	%*	N	%*
Yes disability	44	*46.8%*				
Communication disability			20	*21.3%*		
Difficulty seeing					17	*18.1%*
Difficulty hearing/speaking					3	*3.2%*
Other communication disability					1	*1.1%*
Mental disability			25	*26.6%*		
Learning disability					21	*22.3%*
Developmental disability					2	*2.1%*
Other mental disability					1	*1.1%*
Physical/mobility disability			3	*3.2%*	3	*3.2%*
Chronic health condition			1	*1.1%*	1	*1.1%*
Other disability			9	*9.6%*	9	*9.6%*
No disability	32	*34.0%*	32	*34.0%*	32	*34.0%*
Unknown/preferred not to answer	14	*14.9%*	14	*14.9%*	14	*14.9%*
Missing/did not answer	4	*4.3%*	4	*4.3%*	4	*4.3%*
TOTAL	**94**	***100%***				

* Totals may add to more than 100% since participants could indicate multiple disabilities.

Veteran Status	N	%
Yes	1	*1.1%*
No	81	*86.1%*
Unknown/preferred not to answer	8	*8.5%*
Missing/did not answer	4	*4.3%*
TOTAL	**94**	***100%***

Gender: Assigned Sex at Birth	N	*%*
Male	40	*42.6*
Female	51	*54.3*
Unknown/preferred not to answer	1	*1.1*
Missing/did not answer	2	*2.1*
TOTAL	**94**	***100%***

Gender: Current Gender Identity	N	%
Male	39	*41.5%*
Female	49	*52.1%*
Genderqueer	2	*2.1%*
Unknown/preferred not to answer	3	*3.2%*
Missing/did not answer	1	*1.1%*
TOTAL	**94**	***100%***

INNOVATIVE MOBILE HOARDING INTERVENTION PROGRAM (INNOVATIONS-17)

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

The Innovative Mobile Hoarding Intervention Program (IMHIP; INN-17) program is funded through the Innovations (INN) component of the Mental Health Services Act. The overall goal of IMHIP is to diminish long-term hoarding behaviors among older adults through participation in a multi-faceted intervention, which combines an adapted cognitive behavior rehabilitation therapy with training and support. A key feature of this program is the use of peer support partners with prior "lived experience" receiving treatment for hoarding behaviors to provide support and encouragement to IMHIP participants. Additionally, IMHIP services are provided in the home of the participant, which is expected to facilitate participation in the program and provide opportunities for more direct service provision of the home environment. This intervention is expected to reduce hoarding behaviors and improve the participant's overall quality of life.

EXECUTIVE SUMMARY

The Innovative Mobile Hoarding Intervention Program (IMHIP; INN-17) began providing services in April 2016. Therefore, minimal data collection had occurred prior to 6/30/2016.

Evaluation results for IMHIP will be included in the next INN Annual Report cycle.

For additional information about the INN–17 Innovative Mobile Hoarding Intervention Program please contact:
David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

Behavioral Health Services
Mental Health Services Act Innovation Program and Expenditure Plan
Fiscal Year 2017-18 through Fiscal Year 2023-24

Cycle 3 expansion and extension proposals:

INN 11—Caregiver Connections

INN 12—Family Therapy Participation

INN 15—Peer Assisted Transitions

INN 16—Urban Beats

INN 17—Crest Mobile Hoarding Units

Cycle 3 projects were approved by the Board and by the Mental Health Services Oversight and Accountability Commission (MHSOAC) in 2015 and are currently in operation. The proposals for Cycle 3 expand operations starting in FY 2017-18 and extend the duration of the projects, as indicated. The totals provided are for the duration of the project. Cycle 4 proposals are new projects.

Innovation Evaluation services for each Innovation program are budgeted independently from direct program costs within this proposal as the funds are allocated to a separate provider. The detailed proposed increased evaluation costs totaling $1,967,007 are outlined at the end of this document.

Caregiver Connection (INN 11) Project Overview

Original Duration: July 1, 2015 through June 30, 2018 (3 Years)
Original Budget for Entire Term: $655,338 *(excluding evaluation costs)*
Proposed Extension and Expansion Term: September 1, 2017 through December 31, 2019
Proposed Budget Increase for Extension and Expansion: $1,347,362 *(excluding evaluation costs)*
Proposed Revised Total Program Budget Including Extension and Expansion: $2,002,700 *(excluding evaluation costs)*

Purpose: To support caregivers of children with serious emotional disturbance receiving outpatient clinical services by screening them for mental health needs, providing group support and treatment services and connecting them to their own individual treatment. By identifying, acknowledging and addressing caregiver mental health needs, caregivers will be empowered to more effectively address needs of their children and thrive.

How: Through the provision of caregiver screenings, assessments, group counseling services and direct connection to individual treatment for caregivers. Funding is provided for licensed/license eligible clinicians to screen and assess caregivers for behavioral health concerns and subsequently provide specialty groups to educate families about behavioral health issues, stigma and the impact of caregiver illness and stress on child development. Specially trained parent care coordinators ensure that caregivers in need of individual behavioral health services are connected to the appropriate resources and function as a liaison between the child's treatment team and the caregiver's provider.

Why: Based on community input and system analysis, caregivers with behavioral health conditions and the additional unique burden of caregiver stress were not consistently accessing treatment services. This lack of treatment had a negative impact on the child's treatment and the greater family unit's ability to thrive. Historically, funding regulations had limited BHS-CYF from providing services specific to the caregiver, so Innovations funding coupled by expanded Medi-Cal access for adults afforded the opportunity to support caregivers with a goal of creating a healthier family unit.

Where: In specialty mental health outpatient programs where children are receiving services.

Who: Supports parents and/or caregivers of youth receiving specialty mental health outpatient services who have been identified to experience behavioral health issues and/or caregiver stress. Proposed Clients Served Annually: 900

Innovative Components: Programs serving children have historically focused on the child's needs and the parent / child interaction and have, at best, provided referral information to caregivers for their own behavioral health needs. The Caregiver Connection program provides co-located staff who focus on the caregiver's behavioral health needs, provide screening and assessment services, plays a role in education about the toll of caregiver stress, provides support and group treatment on-site, and more robustly connects caregivers to their own individual treatment, when appropriate.

Proposed Change: Initially, a program that served youth age 0-5 was augmented with caregiver support staff. The proposed change extends the existing child (0-5 years old) program by 1 ½ years and explores the impact of expanding support to caregivers of both latency age youth (6-12 years old) and adolescent youth (13-18 years old). These changes will allow for a greater number of caregivers to be served, allowing a more comprehensive ability to understand how to best support caregivers of various racial, ethnic, cultural and linguistic backgrounds. By expanding to support caregivers of older children, there will be an opportunity to examine how support of the caregiver impacts the outcomes of treatment for youth of varying ages.

Research Questions:

- Will these new approaches lead to improved access to mental health services for unserved and underserved?
- Will caregiver connection to education, resources and treatment lead to improved outcomes for the children who depend on them?
- Does the age of the child in treatment have an impact on the caregiver's connection to treatment?
- Are treatment outcomes different for children of varying ages when support is provided to the caregiver?
- Identification of best practices for supporting caregivers of varying cultural, racial, ethnic and linguistic backgrounds.

Family Therapy Participation (INN 12) Project Overview

Original Duration: July 1, 2015 through June 30, 2018 (3 Years)
Original Budget for Entire Term: $3,232,242 *(excluding evaluation costs)*
Proposed Extension and Expansion Term: September 1, 2017 through December 31, 2019
Proposed Budget Increase for Extension and Expansion: $4,132,831 *(excluding evaluation costs)*
Proposed Revised Total Program Budget Including Extension and Expansion: $7,365,073 *(excluding evaluation costs)*

Purpose: To provide education to caregivers regarding the importance of family involvement in treatment and motivate caregivers to participate regularly.

How: The program trains Parent Partners (peer partners) in Motivational Interviewing with the purpose of engaging caregivers so that there will be increased family participation in family therapy. Emphasis is on teaching the caregiver the benefit of active engagement in the treatment process and addressing barriers on an individual basis. The Parent Partner works with the parent to overcome identified barriers and to assist the multidisciplinary team to better accommodate the family needs in order to foster participation.

Why: Literature shows that family-based therapy can lead to improvement in multiple domains of psychosocial functioning and improvement in behavioral health outcomes. Though there are County-set goals for family therapy participation, literature review and anecdotal reports suggest that increased involvement leads to better outcomes for youth and their families.

Where: Outpatient programs where children are receiving specialty mental health services.

Who: Parents/caregivers of children receiving specialty mental health services. Proposed Clients Served Annually: 960

Innovative Components: This Innovation Project utilizes specially trained Parent Partners in first establishing a relationship with the families of clients, and then using motivational interviewing techniques to overcome barriers to involvement in treatment and activating change. There is no established literature that details the success of Parent Partners trained in motivational interviewing in mobilizing families to participate in family therapy services.

Proposed Change: The initial approved plan was limited to just one program in each of San Diego County's six regions. While preliminary results have demonstrated increased engagement in family therapy services, expansion of services will allow for more meaningful outcomes for the learning objectives stated. Greater numbers will be particularly important to understand the racial/ethnic, cultural and linguistic variables to family participation. The proposed change expands to an additional six locations, one in each region, and extends the existing program for 1 ½ years.

Research Questions:

- Will Parent Partner support increase engagement of parents/caregivers in their children's therapy (as compared to the traditional model of clinician outreach to families)?
- What specific strategies and best practices can Parent Partners utilize to successfully assist the caregiver in seeing the value of consistently participating in family therapy?
- What are the barriers to family participation in treatment?
- Which intervention strategies successfully increased engagement in treatment?
- What are best practices for engaging families of varying racial/ethnic, cultural and linguistic backgrounds?

Peer Assisted Transitions (INN 15) Project Overview

Original Duration: July 1, 2015 through June 30, 2018 (3 Years)
Original Budget for Entire Term: $3,167,631 *(excluding evaluation costs)*
Proposed Extension and Expansion Term: September 1, 2017 through June 30, 2020
Proposed Budget Increase for Extension and Expansion: $2,894,325 *(excluding evaluation costs)*
Proposed Revised Total Program Budget Including Extension and Expansion: $6,061,956 *(excluding evaluation costs)*

Purpose: 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 not effectively connected with community resources through the provision of peer specialist coaching incorporating shared decision-making and active social supports.

How: This project employs Peer Specialist Coaches (PSCs) to serve adults (age 18+) diagnosed with serious mental illness, promoting engagement through peer support, use of 'Welcome Home Backpacks,' social/recreational activities, and to help them connect with relevant services. Peer Specialist Coaches engage the client in designated inpatient settings, such as acute care psychiatric hospitals and crisis houses, and, as part of the discharge team, assist with planned discharge and transition back to the community. Through this expansion, the project will expand to a third crisis house in the region.

Why: Many who use the most acute services do not become effectively connected with relevant follow-up services and have limited social supports; our system has identified the need for better engagement of persons diagnosed with serious mental illness to connect with the variety of services and supports available in the community. The expansion of this project to a third crisis house will be used to test if the usage of Peer Specialist Coaches, instead of staff who are comparable in training without lived experience, has an impact on outcomes.

Where: Currently this project is implemented in 2 Crisis Houses and 2 hospitals; this project is proposing to expand to an additional Crisis House within the region.

Who: Adults (age 18+) diagnosed with serious mental illness. This program is particularly focused on those persons who, in addition to needing to use hospital and/or crisis house services, have a limited social support network and are most likely to not be effectively connected with relevant services. Proposed Clients Served Annually: 300

Innovative Components: The program will make specific use of shared decision-making tools and coaching to support and promote the person's primary decision-making role in identifying relevant services and support in actively planning the discharge with the discharge team and the client together.

Proposed Change: Services are currently provided at 2 crisis houses and 2 hospitals in the County. This proposed change would expand the existing services to a 3rd crisis house where services will be provided by individuals who do not have lived experience to test the effectiveness of Peer Specialist Coaches.

Research Questions:

- Does incorporating a major shared decision-making element into this program, by utilizing resources such as SAMHSA's Shared Decision-Making tools and/or other shared decision-making tools (e.g., elements of the web-based application CommonGround), will result in improved outcomes?
- Can Peer Specialist Coaches at psychiatric hospitals, with the addition of the shared decision-making and social/recreational components, be effectively used to link unconnected patients with an SMI diagnosis to a variety of services and supports in the community? Does the project's focus on providing a peer coach/mentor support, welcome home backpack, and experiences in social/recreational outings increase client engagement, improve well-being, level of functioning and promote the continuation of social activities after their involvement with this program ends?
- Does the specific usage of individuals with lived experience (PSC) increase outcomes or can individuals without lived experience yield the same results

Urban Beats (INN 16) Project Overview

Original Duration: July 1, 2015 through June 30, 2018 (3 Years)
Original Budget for Entire Term: $1,151,031 *(excluding evaluation costs)*
Proposed Extension and Expansion Term: September 1, 2017 through June 30, 2019
Proposed Budget Increase for Extension and Expansion: $878,473 *(excluding evaluation costs)*
Proposed Revised Total Program Budget Including Extension and Expansion: $2,029,504 *(excluding evaluation costs)*

Purpose: To assist transitional-age youth (TAY) in engaging or investing in behavioral health services and/or identifying mental health symptoms and reducing stigma by connecting with TAY through artistic expression.

How: Delivers a customized service to youth created by TAY with a serious mental illness (SMI) and at-risk TAY who incorporate their message into TAY-friendly social media that creatively combines therapeutic, stigma reducing, cultural expression and social justice messaging. The program is intended to engage TAY in wellness activities by providing a youth-focused message created and developed by youth. These may include the visual arts, spoken word, videos, and performances.

Why: Stakeholders expressed that TAY have long been difficult to engage and retain in mental health services. This approach provides wellness activities and messaging in an innovative way that proposes to reach TAY who otherwise would remain disconnected from or prematurely leaves our system of care. Urban TAY often encounter stigma within their community regarding both accessing and maintaining behavioral health services. TAY often report feeling disconnected from traditional services and the people providing them.

Where: This program is currently being offered in the Central Region and the expansion is to include the N. Central Region and the East African Community.

Who: Transitional-Age Youth experiencing serious mental illness or are at-risk of behavioral health conditions. Proposed Clients Served Annually: 800

Innovative Components: This project is an adaptation to existing similar programs and it is designed to test whether a culturally sensitive program that focuses on engagement via multiple models of artistic expression is successful at engaging severely mentally ill TAY that are currently enrolled in behavioral health programs as well as at-risk TAY who may develop behavioral health conditions.

Proposed Change: To increase staffing by 3 FTE to expand and extend services to additional clients in the North Central region, provide a therapist on staff to provide assessment, linkage and short term treatment and funding to provide transportation to enhance outreach and performance venues for clients. Additionally, add a third academy track through a subcontract for the East African TAY Community.

Research Questions:

- To learn whether engaging TAY in a youth friendly and artistic manner improves outcomes by enhancing wellness, coping strategies, access to care, ILS, and ability to socialize in a positive healthy manner, while imparting a message of wellness to other TAY.
- To learn if the purposeful integration of elements of artistic expressions and culture facilitated in a therapeutic setting increases access or acceptance of services and increases the level of functioning by participating in meaningful activities.
- To evaluate alternative strategies that can be integrated into our traditional TAY service array and used to engage SMI and at-risk TAY in mental health servcies more consistently and effectively.
- To evaluate whether the inclusion of a therapist on staff increases connection to services.
- To evaluate if this innovative model will work with specific populations (East African TAY)

Crest Mobile Hoarding formerly IMHIP (INN 17) Project Overview

Original Duration: February 1, 2016 to December 31, 2018 (2 Years, 8 Months)
Original Budget for Entire Term: $1,265,322 *(excluding evaluation costs)*

Proposed Extension and Expansion Term: September 1, 2017 to June 30, 2020
Proposed Budget Increase for Extension and Expansion: $1,253,555 *(excluding evaluation costs)*
Proposed Revised Total Program Budget Including Extension and Expansion: $2,518,877 *(excluding evaluation costs)*

Purpose: Improve health, safety and quality of life, decrease hoarding behaviors, and decrease housing instability in older adults.

How: Diminishes hoarding behaviors long term in Older Adults by combining an adapted cognitive- behavior-rehabilitation therapy with hands-on training and support. The team consists of specially-trained professionals and peers who will also collaborate with the participants other health providers. An aftercare support group helps participants maintain the skills learned. Change adds staff to serve more clients and extends one year.

Why: Hoarding is particularly dangerous for older persons, who may have physical and cognitive limitations. Basic functioning in the home may be impaired as the acquisition of items piled up in various rooms prevents the use of the rooms intended function. Hoarding can present a physical threat due to fires, falling, unsanitary conditions, and inability to prepare food. Many suffer from great social impairment due to the unwelcoming state of the home. Most Older Adults live on a fixed income and suffer from financial problems due to paying for extra storage space; purchasing unneeded items, or housing fires. Older Adults are at risk for eviction or premature relocation to less desirable housing.

Where: Residential homes of referred clients.

Who: Older adults referred for hoarding behaviors that impact daily living and risk for eviction. Current program serves 30 clients in the Central/North Central Regions. The program is expanding to South Region. Proposed Clients Served Annually: 50

Innovative Components: The mobile nature of the project increases access to services for a population of older adults who tend to be isolated and who have many times lost their social contacts and family connections due to the hoarding behaviors. There are few trained professionals that have specialized expertise in this area or are able to make house calls to coach individuals to de-clutter and/or teach them new skills to manage compulsive hoarding. This program design addresses these issues and further, provides case management, peer support, family services, collaboration with the older adult's other treatment professionals, linkage to additional community services and aftercare services.

Proposed Change: Change adds staffing to expand to the South region to serve an additional 20 clients that will better meet the cultural needs of the San Diego population and will provide Spanish/English bilingual services and to extend the current program by one and one-half years.

Research Questions:

- What is an effective model to treat hoarding behaviors in Older Adults with serious mental illness?
- What are the most effective ways to engage an Older Adult to participate in interventions geared for hoarding behaviors?
- Are peer supports and family services effective with Older Adults who have hoarding behaviors either individually and/or as part of an aftercare support group?

Appendix J

Innovation Proposals – Cycle 4

Innovative Project Plan Description

County: San Diego County **Total Funding Request**: $2,250,000

Project Name: Postpartum **Duration:** July 1, 2018 – December 30, 2022

Project Overview

1. Primary Problem

The Children's System of Care Committee (involving stakeholders from multiple entities: public, private, education, family/youth, health plans, Public Health, Child Welfare Services, Probation, etc.) identifies "hot topics" of concern, and there has been extensive discussion about perinatal parental mental health as a "hot topic." Its Early Childhood subcommittee has been reviewing best practices and educating the System of Care Committee on the importance of parental mental health during the perinatal period for optimal early childhood development. Local stakeholders, through the 12 public forums hosted by the County of San Diego, additionally identified mental health screening and provision of appropriate and accessible services for new parents as an area of concern.

The County of San Diego has devised an Innovation Project designed to screen parents for perinatal mood and anxiety disorders and to provide linkages to appropriate resources and care. Postpartum non-psychotic depression is the most common complication of childbearing affecting approximately 10-15% of women and as such represents a considerable public health problem (Warner et al, 1996). The effects of postnatal depression on the mother, her marital relationship, and her children make it an important condition to diagnose, treat and prevent (Robinson & Stewart, 2001). Literature shows that for children, a mother's ongoing depression can contribute to emotional, behavioral, cognitive and interpersonal problems in later life (Jacobsen, 1999). Literature further reveals untreated maternal depression can lead to poor parenting practices, issues with mother-child bonding, to the extremes of abuse and neglect of the child. Maternal depression is also associated with pre-term birth, low birth weight, increased crying, delays in language development, and behavior problems. Though there is markedly less scientific literature available and historically less focus in public health, paternal depression can also lead to issues such as insecure attachment, emotional problems in the child, behavioral issues in the child, and increased parental conflict. (Singley, 2012)

The ability to identify mothers and fathers experiencing depression and anxiety symptoms, as early as possible, can markedly reduce the negative consequences that result from untreated mental health concerns. Despite an increasing body of literature, there is incomplete consensus regarding specific risk factors for postpartum depression. Even less literature is available regarding the development of perinatal mood and anxiety disorders for fathers. The County of San Diego has devised an Innovation Project utilizing what is known about specific risk factors to create a program for screening mothers and fathers and to provide linkages to appropriate behavioral health resources.

As described above, the need for increased screening and linkage to services for perinatal behavioral health issues has been highlighted as a need by community members at the Community Forums and in our Children's System of Care Council. This Innovation Project funding opportunity, coupled with greater availability of behavioral health resources to adults not previously eligible for services prior to

the passage of the Affordable Care Act, can lead to the creation of a program to screen mothers and fathers for perinatal behavioral health issues and link them to services and other resources. Behavioral Health Services-Children Youth and Families (BHS-CYF) has long been a staunch supporter of Early Childhood Mental Health research and programs and views this project as an extension of those efforts. By familiarizing families with behavioral health services, and linking them to services when appropriate, BHS-CYF views this program as an introduction for families to our System of Care and believes this familiarity will both reduce the potential need for use, but also afford easier, less stigmatized access later when, and if, services are again necessary.

2. What Has Been Done Elsewhere To Address Your Primary Problem?

a) 2015 American College of Obstetricians and Gynecologist (ACOG) recommends that clinicians (OBGYNs) screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool. ACOG recommendations further note that, although screening is important for detecting perinatal depression, screening by itself is insufficient to improve clinical outcomes and must be coupled with appropriate follow-up and treatment when indicated. Patients should be subsequently referred to appropriate behavioral health resources when indicated and systems should be in place to ensure follow-up for diagnosis and treatment.
b) County of San Diego BHS has a contracted program that provides telephonic consultation to primary care and OBGYN practices that serve the Medi-Cal population.
c) County of San Diego BHS proposes an Innovative project that provides screening for peripartum mood and anxiety issues and linkage to services at additional locations to increase identification of mothers and fathers and to provide additional opportunities for linkage to services.
d) Specific risk factors for perinatal mood and anxiety symptoms include socioeconomic disparity, inadequate social supports, use of substances such as tobacco, alcohol, or illicit drugs, and the pregnancy being unplanned.
e) Additional risk factors that are present for refugee and immigrant families include the stressors related to migration and resettlement.
f) There is limited literature available regarding screening mothers for peripartum mood and anxiety issues in specific locations outside the OB-GYN office. One study screened women at Women Infant and Children (WIC) offices.
g) In the aforementioned study, the following barriers were identified when women were screened at a WIC program: (1) literacy barriers, (2) need for referrals and follow-up with outside services, (3) training and capacity needs, (4) stigma of depression, and (5) location and privacy of screening. While there is proven benefit, screening did not include fathers and linkages to resources was not a focus of this particular study. (Tabb et al, 2015)
h) County of San Diego plans to incorporate awareness of these specific barriers and is well suited to address, in particular, issues pertaining to referrals and follow-up with outside services.
i) Current screening for pre- and postnatal depression primarily focuses on the mother. Increasing research has indicated a need for screening and intervention services for fathers as well. (Singley, 2012)
j) In the 2010 Maternal and Infant Health Assessment Survey, the snapshot for San Diego

County indicated that 13.8 percent of the women giving birth in San Diego County are diagnosed with postpartum depression. This is consistent with World Health Organization data.

k) Emerging research has also highlighted the increased cases of postpartum anxiety disorders, which are often co-morbid with depressive symptoms. The vast majority of these women never receive treatment.

l) Socioeconomic deprivation indicators such as unemployment, low income and low education have been cited as risk factors in mental health disorders (Bartley, 1994; Jenkins, 1985; Patel et al., 1999; Weich et al., 1997; World Health Organization, 2001). Socioeconomic deprivation has been correlated with postpartum depression (Beck, 2001)

m) Groups such as teen parents, refugee/immigrant families, families struggling with poverty, and mothers with substance abuse issues can all be at higher risk for postpartum depression due to the additional psychosocial risk factors, increased stressors, and inadequate social support.

n) At-risk groups identified above historically have limited engagement with mental health care, and routine prenatal appointments have been found to be inadequate in identifying depressive symptoms in women. (Nonacs, 2016)

o) Recent studies have also highlighted the need to assess fathers for depressive symptoms in the prenatal and postnatal period. (Singley, 2012)

p) While literature around paternal depression is less available, studies indicate paternal postpartum depression affects between 4 and 24 percent of expectant and new fathers. (Soliday, McCluskey-Fawcett & O'Brien, 1999)

q) The ability to identify mothers and fathers experiencing depressive and anxiety symptoms, as early as possible, can markedly reduce the negative consequences that result from untreated mental health concerns.

3. The Proposed Project

This proposed project aims to apply a promising community driven practice approach that has been successful in non-mental health contexts or settings to the mental health system. In an effort to provide increased access to services for perinatal depression and anxiety, this project will work in conjunction with the Public Health Nurses (PHN) Home Visiting programs, Nurse Family Partnership (NFP) and Public Health Services' Maternal Child and Family Health Services Branch (MCFHS).

a) The Nurse Family Partnership is a home-based prevention program that links public health nurses with low income, first time mothers. Clients must enroll in the program prior to their 28th week of pregnancy. Nurses begin home visits early in the mother's pregnancy and continue visitation until the child's second birthday. Nurses provide support, education and counseling on health, behavioral and self-sufficiency issues. First-time mothers can expect to receive referrals to healthcare, childcare, job training and other support services available in their community.

b) The Maternal Child and Family Health Services provides nurse home visitation services to at-risk, low income, pregnant, and postpartum women and their children ages 0-5 years. Nurses provide support, health and parenting education, address bonding issues, medical, and mental risks. Families can expect to receive case management and referrals to

healthcare and support services available in their community. The program's goal is to improve birth outcomes, access to health care, and promote health and well-being for high risk women and their children.

c) The Nurse Family Partnership and Maternal Child and Family Health Programs have been successful with improving the health outcomes of the clients they serve. One area that the program has struggled with is the referral and linkage to mental health services. This is due in part to barriers in access to services, clients being overwhelmed by their current situation, and stigma related to accessing mental health services.
d) Approximately 1,100 families, both single and two parent, with mothers who are pregnant or have a child under the age of two are currently being served by the Nurse Family Partnership and Maternal Child Family Health Programs.
e) Due to the variance of clients served in each Region of the County, the 3 regions reporting the most need for assistance with mental health services would be chosen for this Innovation Project.
f) Priority efforts shall be made to engage underserved populations such as refugee families, Latinos and African Americans.
g) Proposed locations include the South Region and North Regions that include a high proportion of Latino families, and the Central Region that includes high proportions of both Latino and African American families, and refugees.
h) Those clients linked with the PHN programs are typically struggling with socio-economic deprivation, a known risk factor for postpartum depression.
i) As part of the assessment process for clients, the PHN programs conduct screenings on mothers and fathers, which include questions related to depression and anxiety.
j) Currently, for those clients that screen positive, the PHN will provide the client with information about mental health services.
k) A need for additional supportive services to assist mothers and fathers in need of services has been identified.
l) The proposed program will provide case management services to work in coordination with the PHNs, in order to assist the clients in locating services, and ensuring that the client is able to engage and follow through with the needed services.
m) Based on the results of the depression and anxiety screening tool that will be given to clients by the Public Health Nurse, case management staff will coordinate with the PHN staff to identify families in need of linkage to mental health services.
n) Several postpartum depression scales are available and have been tested for reliability and validity. The instrument recommended due to its length and proven validity being administered in various languages, such as Spanish and Persian, is the Edinburgh Postnatal Depression Scale (EPDS). The EPSD is a 10-question screening tool that is brief and easy to answer. Other evidence based screening tools may also be considered for use.
o) Currently, the PHN programs utilize either the Edinburgh Postnatal Depression Scale or the Patient Health Questionnaire 2 and 9 to screen both mothers and fathers.
p) Those families that screen positive for depression and/or anxiety symptoms will be offered case management and treatment services by this provider.
q) Short term case management services will link clients with appropriate mental health and supportive services offered in the community.
r) Utilizing the case management services will help to ensure that clients in need of services do

not struggle to link with and engage in mental health services and supports. The case manager will provide supportive services and coordination to the family.

s) Additionally, the program will provide mental health services to assist those clients that are unable to be immediately linked with mental health services in the community.
t) This program will provide education and outreach materials to be available for distribution by the PHN programs and posting at locations such as the Public Health Centers.
u) This project is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320.

4. Innovative Component

This program aims to apply an approach from outside of mental health services, and utilize it to increase access and participation to mental health services for a traditionally underserved population. Embedding staff with the Public Health Nursing Programs will allow access to clients that are at increased risk due to the psychosocial and socioeconomic factors, known risk factors associated with peripartum mood and anxiety problems. This population has also been shown to underutilize mental health services due to stigma-related issues, lack of knowledge regarding behavioral health symptoms and lack of knowledge of treatment and treatment resources. Screening, referral, and treatment options will be designed to be culturally sensitive and accessible to the target groups, which will include fathers. Engagement and efficacy will be tracked and compared between cultural groups.

5. Learning Goals / Project Aims

a) To learn if collaboration with the PHN home visiting programs is effective in engaging and screening mothers and fathers for perinatal depression and anxiety.
b) To learn if collaboration with the PHN Home Visiting programs is effective to link identified individuals to appropriate services for perinatal depression and anxiety.
c) To identify how to best equip the PHN for effectively screening and connecting both mothers and fathers to services related to maternal/paternal depression or anxiety.
d) To learn if fathers are willing to participate in screening and engagement efforts and to better understand the characteristics of paternal symptomology.
e) To evaluate the effectiveness of culturally competent screening and referral, and the outcomes of engagement and efficacy of culturally appropriate interventions.
f) To learn what percentage are linked to existing resources.
g) To identify the potential magnitude of a system gap, if any.

6. Evaluation of Learning Plan

a) Data collection will include:
    i. number of individuals offered a survey and the number of completed surveys gathered
    ii. gender, ethnicity, and age of respondents
    iii. percentage of clients that screened positive for depression and/or anxiety symptoms
    iv. percentage of those that screen positive that are female and those that are male
    v. number of clients that are assisted through case management services, with breakdown of genders

vi. number of clients that are linked to behavioral health services in the community, with breakdown of genders
vii. number of clients, and length of time, clients are assisted by the program clinician while awaiting linkage to ongoing supports.

b) Data collection methods will be tasked to the program
c) Data will be collected during each encounter
d) The contract shall be monitored and evaluated in the following ways:
   i. Quarterly Status Reports by program
   ii. Data elements that will be tracked and monitored by the program
   iii. Independent Evaluator shall complete annual reports and final evaluation of effectiveness of the intervention

7. **Contracting**

All contracts are handled through San Diego County's Department of Purchasing and Contracting (DPC), which processes more than $1 billion in public purchases and contracts each year. The County posts its requirements for goods and services on BuyNet, an online public system. Procurements will normally be posted on BuyNet under formal Request for Bid (RFB) or Request for Proposal (RFP) solicitations. The department's aim is sound procurement processes to acquire the highest quality goods and services at the best price.

a) Quality and regulatory compliance elements are included in each contract, specific to the funding source and purpose of the service. Proposals are selected in part on the basis of the offeror's plan to achieve best possible quality and compliance with all relevant regulations. A Contract Officer's Representative (COR) with Behavioral Health Services assumes responsibility for ongoing monitoring of the contract for compliance and outcomes, working with the DPC. Monitoring includes regular site visits, review of documentation, and oversight of applicable laws and regulations.
b) A percent of project funds is set aside for an evaluation contract with a qualified research organization.
c) Contractors will have a dedicated COR or Program Monitor from Behavioral Health Services who will develop a contract monitoring plan containing activities that will be conducted over each year on their Statement of Work (SOW). Monthly COR meetings are routine.
d) There will be a minimum of four (4) monitoring activities per contract year, including a minimum of one (1) site visit, with subsequent visits, as needed, if identified problems/issues have not been resolved.
e) Monthly COR meetings and site visit activities include but are not limited to deliverables review, technical assistance and consultation, review of fiscal and claim documentation and annual inventory update, emergency planning documentation, corrective action plans, discussion of strengths and weaknesses of contractor's deliverable outcomes.
f) Monthly review of SOW contract deliverables to determine contractor's performance in meeting contract objectives, review contractor exclusion/department/Medi-Cal Sanctions lists the employee's review process as well as a minimum of two (2) in-depth invoice reviews.

Additional Information for Regulatory Requirements

1. Certifications

a) Board of Supervisors (BOS) authorization will be requested by TBD
b) Certification from the Behavioral Health Director will be included
c) Certification from the Behavioral Health Director will be included
d) Documentation will be provided on the County's PEI and CSS allocation

2. Community Program Planning

a) Twelve (12) community forums were conducted county-wide to get community input and feedback regarding the Innovative project.
b) The Older Adult, Adult and Children, Family and Youth Councils were also solicited for input regarding the community's need.
c) After ideas for the Innovation Project was solidified, community members also participated in "conversation cafes" to discuss the proposed project and given opportunity to provide feedback on components needed.

3. Primary Purpose

Increase access to mental health services to underserved groups

4. MHSA Innovative Project Category

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

5. Population

a) Approximately 1,100 families with mothers who are pregnant or have a child under the age of two are currently being served by the Nurse Family Partnership and Maternal Child and Family Health Programs.
b) Due to the amount of variance of clients served in each Region of the County, the 3 regions reporting the most need for assistance with mental health services would be chosen for this Innovation Project.
c) Proposed locations include the South Region and North Regions that include a high proportion of Latino families, and the Central Region that includes high proportions of both Latino and African American families.
d) The case management staff will coordinate with the PHN staff to identify families in need of linkage to mental health services.
e) Currently, the PHN programs utilize either the Edinburgh Postnatal Depression Scale or the Patient Health Questionnaire 2 and 9.
f) The staff person would also be there to provide referral information and support to parents interested in services.
g) Staff will provide short term case management to those individuals who have a positive screen for perinatal depression/anxiety needing assistance enrolling in services.
h) A licensed or license-eligible mental health provider will be available to work with clients that are not able to be promptly linked to appropriate services available in the community.
i) The behavioral health provider will be able to provide individual counseling to mothers or fathers in need of services.
j) Case management staff is expected to assist 300 clients annually.
k) Behavioral health staff is expected to provide direct services to 25 clients annually.

6. MHSA General Standards

This project is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320.

a) **Community Collaboration:** The concept for this work plan was developed based on local stakeholder process for input on system needs over multiple years.
b) **Cultural Competence:** As defined in CCR, Title 9, Section 3200.100, this program demonstrates cultural competency and capacity to reduce disparities in access to mental health services to improve outcomes.
c) **Client/Family Driven Mental Health System:** This program includes the ongoing involvement of clients and family members in roles such as, but not limited to, implementation, evaluation, and future dissemination. Ultimately, the program strives to create healthier families in our community.
d) **Wellness, Recovery and Resilience Focus:** This program increases resilience and promotes discovery and wellness for parents with serious mental illness by increasing access to services. The goal is to strengthen the overall family to allow for a more stable and resilient family system with strength to sustain wellness.
e) **Integrated Service Experience:** This program encourages access to a full range of services provided by community resources, multiple agencies, programs and funding sources for family members.

7. Continuity of Care for Individuals with Serious Mental Illness

Yes, it is feasible that some of the individuals who screen positive for perinatal depression/anxiety will meet the threshold for serious mental illness. Individuals will be connected to appropriate resources.

8. INN Project Evaluation Cultural Competence and Meaningful stakeholder Involvement

a) As defined in CCR, Title 9, Section 3200.100, this program demonstrates cultural competency and capacity to reduce disparities in access to mental health services to improve outcomes and to implement treatment interventions and outreach services to effectively engage and retain individuals of diverse racial/ethnic, cultural, and linguistic populations.
b) Program will ensure that the client identifies the goals important to them for ongoing stability to make certain that treatment planning remains a collaborative process.

9. Deciding Whether and How to Continue the Project Without INN Funds

Throughout the duration of the project, steps will be taken to review the effectiveness of the screening and linkage efforts. If the project is successful, other existing services within the PHN Home Visiting Programs will be evaluated for augmentation to incorporate the screening and linkage offered through this program.

10. Communication and Dissemination Plan

Information regarding this project will be disseminated through multiple collaborative groups, such as the Behavioral Health Advisory Board, the Children's System of Care Council and the Adult System of Care Council. Information regarding the program will also be available on the County of San Diego

website. As this is a collaborative effort with the Regional Welfare offices, the Welfare to Work Program and local supportive services for parents experiencing depression/anxiety, joint meetings will be held to ensure collaboration and communication. Keywords for search are: Perinatal mood disorder; perinatal anxiety disorder; postpartum depression in mothers; postpartum depression in fathers; and postpartum supports in San Diego.

11. Timeline

a) Total timeframe (duration) of the INN Project: 4 Years, 6 Months
b) Expected start date and end date of Project: 7/1/18 Start Date 12/31/22 End Date
c) Key activities timeline and milestones:

Implementation/ Completion Dates: 07/18 – 06/19

By 6/18	Amend contracts or RFP to include innovative component
7/2018	Innovation component goes into effect
7/2018	Services begin
8/2018	Contractor establishes a research and data collection outline to capture outcomes
8/2018	Begin ongoing data collection and evaluations
8/2018;8/2019	Provide comprehensive program assessment and outcome annually
TBD	Provide final program assessment and outcome with recommendations
TBD	Evaluation by Behavioral Health Services to determination of efficacy and feasibility or replication with other funding, dissemination of results

An evaluation component will be embedded within the programs with quarterly data reporting, annual reports and recommendations with a final project review to determine program effectiveness and identify the most successful practices from the implementation phase and measure system impact. This will also allow for review of new and adapted strategies that may increase the feasibility of the program for future replication.

12) INN Project Budget and Source of Expenditures

The next three sections identify how the MHSA funds are being utilized:

Total Funding
$500,000 – 5% evaluation cost ($25,000) = $475,000 annually
Program Manager/Mental Health Clinician - $120,000
3 Regional staff - $90,000 x3 = $270,000
Operational Costs - $85,000

Contractor shall coordinate with County contracted Behavioral Health Service providers and Community Based Behavioral Health Providers to engage parents in need of behavioral health services with weekly individual and group therapy.

INN 18 Perinatal						
New Innovative Project Budget by FISCAL YEAR (FY)						
BUDGET TOTALS	**FY 18/19**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**TOTAL**
Personnel	$390,000	$390,000	$390,000	$390,000	$195,000	$1,755,000
Direct Costs						
Indirect Costs						
Operating Costs	$85,000	$85,000	$85,000	$85,000	$42,500	$382,500
Non Recurring Costs						$0.00
Other Expenditures						
INNOVATION BUDGET	$475,000	$475,000	$475,000	$475,000	$237,500	$2,137,500
Evaluation 5%	$25,000	$25,000	$25,000	$25,000	$12,500	$112,500
TOTAL	**$500,000**	**$500,000**	**$500,000**	**$500,000**	**$250,000**	**$2,250,000**

- Warner, R., Appleby, L., Whitton, A., & Faragher, B. (1996). Demographic and obstetric risk factors for postnatal psychiatric morbidity. British Journal of Psychiatry, 168, 607-611.

- Jacobsen, T. (1999). Effects of postpartum disorders on parenting and on offspring. In L.J.Miller (Ed.), Postpartum Mood Disorders (pp. 119-139). Washington, DC.: American Psychiatric Press.

- Nonacs, R. (2016) HEART: An Innovative Porgram for Identifying and Treating Adolescent Mothers with Depression. Women's Mental Health.

- Singley, D. (2012) Toward a Whole Family Perspective on Reproductive Mental Health: Paternal Postpartum Depression. The San Diego Psychologist Newsletter, San Diego Psychological Association

Innovative Project Plan Description

County: San Diego County **Total Funding Request**: $4,617,787

Project Name: Telemental Health **Duration:** July 1, 2018 – December 30, 2022

Project Overview

1. Primary Problem

The primary purpose of the Innovation Project is to increase access to appropriate outpatient behavioral health services after a psychiatric emergency in which the client utilized psychiatric hospitals, emergency screening and/or crisis response services. The goal is to ultimately reduce the recidivism rate of clients utilizing emergency services by promoting linkage to outpatient services for continued stabilization.

The County of San Diego tracks outcomes of clients unconnected to outpatient programs, who enter psychiatric hospitals, emergency screening and crisis response services. A review of client follow-up post-emergency services reveals that many unconnected clients are not accessing outpatient services after utilization of emergency services (County of San Diego CO-19 report). Data collected regarding clients with a history of recidivism with no connection to outpatient or case management services includes:

a) 224 Children (5-17yo) from inpatient psychiatric hospitals (Rady CAPS, Aurora, Sharp Mesa Vista), Emergency Screening Unit and PERT
b) 1113 Adults/Older Adults (including Transitional Age Youth populations) from inpatient psychiatric services at SDCPH

Recidivism for hospitalization or crisis services most frequently occurs 30-90 days after client's discharge from hospital or crisis intervention service (County of San Diego CO-20 report).

A review of literature reflects barriers cited by providers and clients in receiving follow-up services include the following: poor insight, lack of motivation, not understanding the benefits of mental health services, lack of transportation, stigma and financial constraints (Burnett, L., Davis, E., Lynch, E. 2014). This is consistent with what we anecdotally experience locally.

In the Children's System and for select clients in the Adult Older Adult (AOA) System, the caregiver's willingness to accept follow up services can be impacted by barriers mentioned above, as well as the stress of taking on another commitment.

Current treatment programs in the County of San Diego System of Care (SOC) focus on helping clients transition out of psychiatric hospitals and crisis settings through providing community based services at the client's residence or at traditional outpatient clinic programs. All existing services rely on face-to-face contact with the provider. The goal of this Innovation project is to increase access to follow-up treatment in order to decrease recidivism by providing Telemental Health to a population that is experiencing barriers with receiving available behavioral health services. The implementation of this service would also enhance continuity of care.

Crisis, Action & Connection (CAC) is the current provider for the Children's SOC when clients transition from a psychiatric hospital or the Emergency Screening Unit (ESU). The program relies on the referrals from ESU and hospital staff to link children and youth to follow up services. CAC

provides face-to-face support and assessment. CAC is available to initiate services prior to discharge, however short length of stay coupled with other barriers limit CAC's ability to initiate service in the crisis or inpatient psychiatric setting with 100% of children and youth.

Next Steps and Transition Team are the current providers for the Adult SOC when clients transition out of Emergency Psychiatric Unit (EPU), inpatient services at San Diego County Psychiatric Hospital (SDCPH), and other local psychiatric hospitals. Next Steps and Transition Team provide face-to-face support and assessment. Reasons for non-compliance and lack of follow through with the services offered include the following: lack of motivation to receive treatment, presence of a co-occurring disorder, lack of insurance needed for aftercare programs and the individual feeling overwhelmed about mental health obstacles.

2. What Has Been Done Elsewhere To Address Your Primary Problem?

To determine this as an appropriate modality of service delivery, a literature review was conducted and it was noted Telemental Health has been utilized in Europe for over a decade with great success (Richards D. 2015-Healthcare ITNews). Additional reports highlight the increasing prevalence and success of this delivery method in the US.

a) Findings have demonstrated that Telemental Health is a viable form of treatment delivery for adults with a number of disorders, particularly those who may underutilize formal services or not follow up with referrals to appropriate agencies. (Jones, A. et al.- Psychol Serv. 2014 Nov.)
b) Recent research and literature establishes that Telemental health is an effective (e.g., positive outcomes, parent and clinician satisfaction) treatment delivery modality for youth. (Ellington & McGuinness, 2011; Myers, Valentine, & Melzer, 2008; Van Allen, Davis, & Lassen, 2011)
c) Literature shows that providing Telemental healthcare services to patients living in rural and underserved areas significantly reduced psychiatric hospitalization rates. (Lerman, A., Quashie, R.-Bloomberg BNA Health Law Reporter-June 2016)

Telemental Health services have proven effective for outpatient care, with research confirming that clients are able to establish rapport with the provider and that the modality affords reliable assessment, diagnosis and treatment. Continued advances in technology have made Telemental Health an increasingly viable option for service, and is presently supported by Medicaid/Medicare and a variety of private insurance agencies. Telemental Health has been demonstrated to be a feasible and cost-effective method for delivering evidence-based treatment to underserved populations who may not otherwise access formal mental health services. (Yuen, Goetter, Herbert, & Forman, 2012)

While Telemental Health has been studied for use with the traditional outpatient service level of care, a comprehensive review of literature does not reflect studies detailing the use with clients receiving transitional services post-discharge from inpatient hospitals and crisis services. Supporting clients through Telemental Health could provide the first linkage to follow-up behavioral health support in a less intrusive, less stigmatizing and less stressful manner. Clients that tend to have a high recidivism rate with psychiatric emergencies and hospital admissions could be afforded easy access, continuity of care and a reduction in gaps in treatment for improved prognosis if they had access to Telemental Health services upon discharge.

3. The Proposed Project.

The proposed Telemental Health project would identify clients that are unconnected to behavioral health services admitted to inpatient psychiatric hospitals and/or crisis stabilization units. These clients would be screened in advance of discharge by an on-site case manager to evaluate whether or not Telemental Health might be a realistic option to increase access to behavioral health services to maintain psychiatric stability.

a) The on-site case manager would integrate the primary team's recommendations for service upon discharge.
b) Unconnected clients discharging from the hospital or crisis setting will continue to be offered transitional home based services and/or clinic based services with the addition of Telemental Health to ensure that there is follow-up and linkage to appropriate resources for continuity of care and lasting stability.

This additional option of Telemental Health will be a new approach of providing behavioral health services for the purpose of preventing recidivism with utilizing psychiatric emergency services. The clients screened and identified as being both reasonable candidates for and amenable to Telemental Health will be provided necessary resources in order to access and participate in their follow-up session while still in the hospital or crisis service setting.

a) Clients will be educated and provided assistance with registration for services by the case manager. This would include completing consent forms for treatment, signing release of information documents, etc.
b) Clients would be taught how to navigate the Telemental Health application by the case manager.
c) Case manager will have the client identify a selected device to utilize for service delivery. If client does not have access to an electronic device (i.e. computer or tablet) and necessary WiFi connection availability, technology will be provided to them.
d) Clients will be provided the name of the behavioral health clinician that will be contacting them and an agreed upon time will be established for their follow-up session. In some instances, that initial connection may be in advance of discharge from the facility.
e) The case manager will additionally support the hospital or crisis emergency service staff during the client's discharge planning and offer additional resources when needed.
f) Staffing will consist of 3 FTE Licensed or Licensed Eligible (minimum 1 bilingual) clinicians who will provide therapy sessions and 5 FTE case managers who will conduct the initial screenings to determine the client's amenability and appropriateness for Telemental Health.
g) The clinicians and case managers will be trained on best practices, legal, HIPAA and ethics of Telemental Health to ensure competency with the modality (Higgins, R.-2016-Clinican Resources, Telehealth).

The Countywide need is for 224 children and youth (data from FY 15/16) from local inpatient facilities, ESU and PERT and 1,113 adults (data from FY 15/16) that were provided inpatient services at the San Diego County Psychiatric Hospital to be linked with follow-up services to decrease recidivism of hospitalization and/or crisis services.

Projected target is linking 250 total clients to Telemental Health services which includes screening, education on the device/application and follow-up therapy services.

4. Innovative Components

a) The Telemental Health proposal would augment current behavioral health services with a novel method for service delivery for this population and with the goal of increasing access for high risk clients with the primary purpose of providing follow up services in a modality that meets their needs. This approach assures that there is continuity of care for a population with high rates of recidivism in utilizing emergency crisis services.
b) Telemental Health is a current modality utilized worldwide. However, a review of literature demonstrates that there is not information about existing programs with the specificity of offering a Telemental Health modality to clients discharging from an emergency psychiatric setting.
c) The use of Telemental Health is supported as a promising approach and solution to overcoming barriers that prevent clients from accessing behavioral health services upon discharge from a crisis service.

5. Learning Goals / Project Aims

a) To learn if Telemental Health will lead to increased engagement in outpatient behavioral health services post-discharge from the psychiatric hospitalization and/or crisis stabilization facilities.
b) To learn if Telemental Health decreases the utilization of the of crisis/hospital services within a prescribed period post-discharge.
c) To determine if some clients better engages in treatment when the right modality for the individual is identified.
d) To determine which subpopulations (based upon age, gender, racial/ethnic, linguistic, or cultural determinants) respond best to technology driven services.

6) Evaluation or Learning Plan

a) Children, Youth, TAY, Adult and Older Adult who are unconnected to services and receive care in a psychiatric hospital or crisis stabilization setting will be the target participants. Behavioral Health Services Data from FY 15-16 (C0-19 Report) for unconnected clients highlighting recidivism rates supports this target. Clients will be identified prior to discharging from an emergency psychiatric setting.
b) Data collection will include:
    i. number of individuals screened for appropriateness of Telemental Health services and the number of individuals referred for this service
    ii. gender, ethnicity, and age of those utilizing Telemental Health services
    iii. percentage of clients linked utilizing Telemental Health to outpatient services
    iv. percentage of clients utilizing Telemental Health services who require another psychiatric emergency service
    v. number of clients, and length of time, clients are assisted by the Telemental Health program while awaiting linkage to ongoing supports
c) Data collection will be tasked to the program
d) Data collected from the Telemental Health program will be compared to data from existing reports detailing outcomes for unconnected clients receiving psychiatric emergency services
e) Existing data reports pertaining to this population and related outcomes will continue to be collected and reviewed.

f) The contract shall be monitored and evaluated in the following ways:
   i. Quarterly Status Reports by program
   ii. Data elements that will be tracked and monitored by the program
   iii. Independent Evaluator shall complete annual reports and final evaluation of effectiveness of the intervention

7. Contracting

All contracts are handled through San Diego County's Department of Purchasing and Contracting (DPC), which processes more than $1 billion in public purchases and contracts each year. The County posts its requirements for goods and services on BuyNet, an online public system. Procurements will normally be posted on BuyNet under formal Request for Bid (RFB) or Request for Proposal (RFP) solicitations. The department's aim is sound procurement processes to acquire the highest quality goods and services at the best price.

Quality and regulatory compliance elements are included in each contract, specific to the funding source and purpose of the service. Proposals are selected in part on the basis of the offeror's plan to achieve best possible quality and compliance with all relevant regulations. A Contract Officer's Representative (COR) with Behavioral Health Services assumes responsibility for ongoing monitoring of the contract for compliance and outcomes, working with the DPC. Monitoring includes regular site visits, review of documentation, and oversight of applicable laws and regulations.

A percent of project funds is set aside for an evaluation contract with a qualified research organization.

Contractors will have a dedicated COR or Program Monitor from Behavioral Health Services who will develop a contract monitoring plan containing activities that will be conducted over each year on their Statement of Work (SOW). Monthly COR meetings are routine. There will be a minimum of four (4) monitoring activities per contract year, including a minimum of one (1) site visit, with subsequent visits, as needed, if identified problems/issues have not been resolved. Monthly COR meetings and Site visit activities include but are not limited to deliverables review, technical assistance and consultation, review of fiscal and claim documentation and annual inventory update, emergency planning documentation, corrective action plans, discussion of strengths and weaknesses of contractor's deliverable outcomes, monthly review of SOW contract deliverables to determine contractor's performance in meeting contract objectives, review contractor exclusion/department/Medi-Cal Sanctions lists employee review process as well as a minimum of two (2) in-depth invoice reviews.

Additional Information for Regulatory Requirements

1. Certifications

a) Board of Supervisors (BOS) authorization will be requested by 3/21/2017
b) Certification from the Behavioral Health Director will be included
c) Certification from the Behavioral Health Director will be included
d) Documentation will be provided on the County's PEI and CSS allocation

2. Community Program Planning

a) Twelve (12) community forums were conducted county-wide to get community input and feedback regarding the Innovative project.
b) The Older Adult, Adult and Children, Family and Youth Councils were also solicited for input regarding the community's need.
c) After ideas for the Innovation Project was solidified, community members also participated in "conversation cafes" to discuss the proposed project and given opportunity to provide feedback on components needed.

3. Primary Purpose

To increase access to mental health services

4. MHSA Innovative Project Category

Makes a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community

5. Population (if applicable)

a) Program aims to screen 100% of unconnected clients prior to discharge from identified and enhanced psychiatric emergency settings. Based on the current need, the projected number of clients served annually will be between 350-400 clients.
b) The population served will be Children and Youth (5-17y/o) and Adults/Older Adults (18-60+ y/o) who recently experienced and psychiatric emergency. The program is inclusive of any gender identity, race, ethnicity, sexual orientation or language.
c) Any client in the subset mentioned above discharging from a crisis setting (Psychiatric Hospital, EPU, ESU, PERT) that is not currently connected with a provider in the SOC will be eligible for this service.

6. MHSA General Standards

This project is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320, as follows:

Community Collaboration: The concept for this work plan was developed based on local stakeholder process for input on system needs over multiple years.

Cultural Competence: As defined in CCR, Title 9, Section 3200.100, this program demonstrates cultural competency and capacity to reduce disparities in access to mental health services to improve outcomes.

Client/Family Driven Mental Health System: This program includes the ongoing involvement of

clients and family members in roles such as, but not limited to, implementation, evaluation, and future dissemination. Ultimately, the program strives to create healthier families in our community.

Wellness, Recovery and Resilience Focus: This program increases resilience and promotes discovery and wellness for parents with serious mental illness by increasing access to services. The goal is to strengthen the overall family to allow for a more stable and resilient family system with strength to sustain wellness.

Integrated Service Experience: This program encourages access to a full range of services provided by community resources, multiple agencies, programs and funding sources for family members.

7. Continuity of Care for Individuals with Serious Mental Illness

The program's target population will primarily be those with serious behavioral health needs. Existing efforts to link unconnected clients to services post-discharge will continue when this project ends, and if the innovative component proves successful, efforts will be made to leverage alternative funding streams to provide continued service via the Telemental Health modality.

8. INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement

a) The concept for this work plan was developed based on local stakeholder process for input on system needs. There was overwhelming feedback that Telemental Health service provision be easily accessible, particularly in rural areas. Telemental Health was identified as a viable option to support clients who have difficulty physically accessing services. The community forum participants also proposed partnerships between Telemental Health and on-site support.

b) As defined in CCR, Title 9, Section 3200.100, this program demonstrates cultural competency and capacity to increase sensitivity to the barriers that these clients face with accessing follow-up mental health services to reduce recidivism. The barriers taken into consideration such as cultural factors and beliefs that create stigma regarding receiving behavioral health services, lack of resources for low socio-economic status clients and unique impediments for clients with serious mental health issues.

9. Deciding Whether and How to Continue the Project Without INN Funds

The outcomes data will inform decisions regarding continued provision of this service modality. Existing efforts to support unconnected clients receiving psychiatric emergency services will continue.

10. Communication and Dissemination Plan

a) Information regarding the program, including outcomes, will be shared with stakeholders via the Behavioral Health Advisory Board, Children's System of Care meeting, Adult System of Care meeting, Behavioral Health Program Manager's meeting and presentations to various agency partners (CWS and Probation).
b) Program participants will be given the opportunity to provide feedback about the services through the Telemental health application which will provide them an option to take a survey regarding their satisfaction after each session.

c) Evidence-based Telemental Health, Barriers to Treatment, Aftercare Services for Patients with Severe Mental disorder, Increasing Utilization of Available Mental Health Services, Guidelines for Establishing a Telemental Health Program

11) Timeline

a) Total timeframe (duration) of the INN Project: 4 Years, 6 Months
b) Expected start date and end date: **January 2018** Start Date **June 2022** End Date
c) Key activities timeline and milestones -- TBD ; Development and refinement of the new or changed approach; Evaluation of the INN Project; Decision-making, including meaningful involvement of stakeholders, about whether and how to continue the Project; Communication of results and lessons learned.

Innovative Project Plan Description

County: San Diego County **Total Funding Request**: $8,788,837

Project Name: ROAM Roaming Outpatient Access Mobile **Duration:** January 1, 2018 – June 30, 2022

Project Overview

1. Primary Problem

In San Diego County, factors such as history, culture, geography (rural) and building meaningful and trusting relationships have been identified as barriers to accessing mental health treatment for Native American communities. San Diego proposes to increase access and utilization of culturally competent mental health services Native American rural populations to decrease the effects of untreated mental health and co-occurring conditions through the use of two mobile mental health clinics, cultural brokers and incorporating complimentary traditional Native American healing practices in treatment and services.

Background. There are more Native American reservations in San Diego County than any other county in the United States (San Diego Native American), with some 5,300 individuals living on reservations, covering approximately 193 square miles. Many of these Native American communities do not have behavioral health services that are readily available and easily accessible. Although there are currently three (3) Indian Health centers and two (2) satellite clinics located on reservation land in San Diego County, many still live far away from services. In addition, while these clinics may provide varying levels of behavioral health services, the County of San Diego does not currently have any contracts specific to providing mental health treatment to individuals with severe mental illness (SMI).

All of the reservation land is located in rural San Diego. People living in rural areas are more likely to have significant mental health issues, including substance abuse (Rural Health Network). A study addressing substance abuse in rural America found that rural youth, ages 12 to 17, and transitional aged youth (TAY) ages 18-25, have higher methamphetamine and alcohol use than urban youth; and the more rural and isolated an area is, the higher the usage rate (Lambert, Gale & Hartley, 2008).

San Diego's rural area residents have an overall higher rate of suicide than the rest of the county. In 2011, one (1) out of seven (7) rural adults required help for emotional and/or mental problems (Community Health Statistics (CHS)-Health Status Report Rural, 2012). In addition, national research indicates that suicide rates of Native American/Alaskan Native teens are 2 to 3 times higher than other youth (Mays, 2016) and Native Americans experience serious psychological distress 1.5 times more than the general public and PTSD over 2 times more than the general public (Mental Health America).

While there have been Prevention and Early Intervention (PEI) services provided to this community through the County's contract with the Dreamweaver Consortium member organizations, services are limited to prevention education (suicide prevention and stigma and discrimination reduction) and brief intervention (not longer than 6 sessions). The Dreamweaver Consortium member organizations have indicated a need for more mental health treatment services for Native Americans.

In a Native American community dialogue conducted at the Rincon offices of the Indian Health Council, representatives from various Native American communities within San Diego (n=34) were asked about their communities' behavioral health needs. The following are some points that were communicated during this community conversation:

a) Native Americans have the same behavioral health needs as other communities, but factors such as culture, history and geography serve as unique factors to consider.
b) Geographical isolation (many communities live in remote regions) makes it difficult to access services as they are not provided within the community; many members live on unpaved roads and some tribes are located many miles away from any services.
c) Culture is important and needs to be woven into all efforts – recognizing that some of these values are complex, contradictory and not always uniform.
d) Innovative and resource strategies include:
    i. Incorporate Native American culture into treatment – arts, cultural initiatives and rites of passage, etc.
    ii. Use of technology, i.e. tele-mental health program for follow up appointments
    iii. Adopt a "no wrong door" approach, understanding that people may not come in for behavioral health services, even though that is one of their needs
    iv. Promote recovery from a cultural perspective

With a majority of San Diego's Native American population living in a geographically large rural area, Behavioral Health Services (BHS) concluded that the best method to improve access and utilization of mental health services is to develop two (2) mobile mental health service units deployed to pre-determined locations (e.g. schools, community gathering areas) throughout designated San Diego's Native American Reservations. Additionally, to ensure we provide relevant and culturally competent services, employment of cultural brokers (e.g. tribal leaders, elders, and healers) will be critical to facilitate engagement, access and treatment services for the community and the treatment providers.

Participants in the BHS Community Engagement Forums this past year were invited to discuss this proposed project. They indicated that the project was needed and suggested the addition of community members with lived experience as they could help the mobile unit make the services more acceptable and reduce stigma. The participants also indicated that appropriate marketing could further help reduce stigma.

2. What Has Been Done Elsewhere To Address Your Primary Problem?

Mobile Clinics. The medical field has adopted the usage of mobile clinics to facilitate access to care. A literature review conducted by Harvard Medical School (2016) indicated that Mobile Health Clinics are effective in facilitating access to health care and are considered an effective intervention for physical health needs as well as the Mobile Health Clinics' success in providing preventative services for physical care and its ability to reach and treat underserved populations. This literature review listed the following as barriers to access to physical health care: transportation/geographic barriers, insurance status, legal status, financial costs, linguistic and cultural barriers, psychological barriers, perceived absence of patient-centered care, intimidation by healthcare settings, lack of healthcare providers, hours of operation and anonymity concerns. This literature review also identified a gap in the provision of focused mental health services (inclusive of diagnosis, treatment, follow-up, prevention and early

intervention) in a mobile clinic setting.

The usage of mobile clinics for mental health treatment is relatively new. Typically, when mental health "mobile units" are referenced, this term indicates service providers who are mobile; that is, individual or teams of individuals are deployed when needed to provide outreach, referrals or services in homes and in the community.

During the research phase, BHS identified a single program nationwide that has a Mental Health Mobile Clinic and serves rural communities. Tulare County has 2 Mobile Units that target individuals from rural communities. Phone calls to the two programs that provide the Mobile Unit services indicated that:

a) The North Unit only serves adults 18 years old and over. Services are provided through their mobile unit in conjunction with services provided through their home office. Clients are sometimes brought into the home office to participate in groups or other services. Typically only the case manager and therapist (with the driver) go out in the mobile unit. The psychiatrist has one "doctor day" in which he also goes into the community in the mobile unit.
b) The South Unit serves children between the ages of 2-11 years old and adults over the age of 25. Mobile services are provided in conjunction with services provided at their home office. They also have county nurses that provide physical health screenings and inoculations.
c) While Tulare County does have a Native American population, these programs do not specifically target this population and were unable to provide any data about whether any Native Americans are served through their program.

Cultural Brokers. The usage of cultural brokers to bridge the gap between mainstream medical model treatment and individual culturally diverse communities is not a new practice. Cultural brokers can serve as a cultural guide and mediator for both clients and providers. Cultural brokers can also "serve as a catalyst for change to assist health care providers and organizations in adapting policies and practices to the cultural context of patient populations and communities served" (National Center for Cultural Competence, 2011, p.3).

Current practices indicate that cultural brokers are used only when the provider has expressed frustration or difficulty with engaging the clients from different cultural groups in treatment or adhering to treatment. In some instances, cultural brokers simultaneously work directly with the providers and clients when they are called to action. In other instances, cultural brokers work with providers and clients independently as cultural experts or trusted community leaders/members, respectively.

Finding. Mobile clinic use has been primarily and effectively focused on physical health, with mental health services limited to crisis intervention and screening (Harvard, 2016). The use of vehicular mobile clinics for comprehensive mental health services is currently only being utilized by Tulare County. However, the program is not completely mobile, and does not provide services to Native Americans. While cultural brokers have been used as a bridge between health and human service providers, there appears to be a lack of information and data about incorporating relevant culturally competent interventions and services in the mental health field for Native Americans.

3. The Proposed Project

The Roaming Outpatient Access Mobile (ROAM) program will consist of two fully mobile mental health clinics: one in the North Inland region and one in the East County region (areas that have the highest concentration of Native American reservation land). The ROAM program will operate Monday through Saturday 8:00am-6:00pm with client hours between 9:30am-4:30pm. Each Mobile unit will be staffed with a culturally competent Licensed Mental Health Clinician, psychiatrist (dual board certified), registered nurse, case manager with AOD certification, peer support specialist, family support specialist, cultural broker and support staff. The ROAM program will provide comprehensive services to children and youth with serious emotional disturbances, adults with serious mental illness (e.g. individual/group counseling, medication management, case management, peer and family support, care coordination, and prevention and services as well as Alcohol and Other Drug (AOD) screening, referral and linkage. The program will also apply and incorporate relevant cultural practices that are widely accepted and utilized by the Native American communities and are complementary with traditional western treatment approaches. The target population will be children, youth, families, adults, and older adults of Native American descent living on the various Reservations across San Diego's rural areas. San Diego aims to increase the utilization of mental health services among the culturally diverse, and underserved Native American population to decrease the effects of untreated mental illness by outreaching and promoting engagement in services by integrating the provider team with local community leaders as cultural brokers.

The project will adapt the pre-existing practice of Tulare County, by testing mobile mental health clinics to the unique population and geography of San Diego by focusing on Native American individuals across all age groups living on reservation land. The project will also test engagement of cultural brokers as an embedded component of treatment to evaluate its efficacy in engaging and treating local Native American members as well as evaluating the efficacy of incorporating culturally competent services and traditional healing practices in the treatment model.

In addition, a sub-set of individuals with serious mental illness who have a co-occurring substance use disorder will be identified and provided with adjunct treatment and services such as Medication Assisted Treatment (MAT).

4. Innovative Components

The project takes an evidence-based approach, improving access to care by using vehicular clinics, and adds the following innovative approaches:

a) Staffing the mobile clinics with culturally competent clinicians and cultural brokers from the targeted communities. Contractors shall recruit, retain and employ individuals from the Native American communities.
b) Utilizing and incorporating culturally competent traditional Native American healing practices in treatment plan.
c) Using MAT to assist and support sobriety and recovery for individuals with co-occurring disorders. Untreated mental health conditions are often masked by the use of alcohol or other drugs in the form of self-medication in which clients medicate mental health symptoms by using alcohol and drugs (Foundations Recovery Network). MAT is a

recognized practice that is gaining traction in the Alcohol and Drug field, but much less so in the mental health field, although approximately 49% of adult clients with a serious mental illness have a co-occurring disorder of substance use (BHS Systemwide Annual Report F/Y 14-15).

d) The usage of tele-mental health in conjunction with, rather than in lieu of, in vivo services is a key factor in preventing any additional barriers to treatment and allow for further engagement. Tele-mental health capabilities would allow for follow up "visits" even when the mobile clinic is in a different area. Additionally, there may be a subset of clients who are unable or unwilling to physically come to the mobile clinic (e.g. actively psychotic individuals, who may benefit from tele-mental health technology.
e) GPS location services will be explored so clients and potential clients will have real time information as to where the mobile unit is.

5. Learning Goals / Project Aims

1) Improve access to and utilization of culturally competent mental health treatment and services; 2) Decrease the effects of untreated mental illness, and 3) Decrease behavioral health symptoms and improve level of functioning.

a) Will the use of a focused, dedicated culturally competent mental health mobile clinic improve access to and utilization of services for underserved Native American communities in rural San Diego?
b) Will the integration of cultural competent treatment practices and the use of the cultural brokers embedded within the program increase access and utilization of services and improve mental health treatment outcomes?
c) Will the use of MAT services for co-occurring diagnosed clients decrease substance use among Native American communities in rural San Diego?
d) Will the use of tele-mental health sustain engagement in treatment with clients in Native American communities in rural San Diego?

6. Evaluation of Learning Plan

Target participants are Native American children, TAY, adults, and older adults with severe emotional conditions (children/youth) or severe mental illness (TAY, adults and older adults). To determine whether the learning goals listed above were met, the following approaches will be utilized:

<u>Data to be Collected</u>

a) Demographics, including but not limited to age, race, ethnicity, gender, sexuality, disability, veteran status, diagnosis, and primary language will be collected
b) Client satisfaction with integration of culturally competent services and cultural brokers
c) Client outcomes such as engagement in treatment, decrease in symptoms and negative behaviors, increased understanding of mental health, attaining educational and employment goals, and increase in socialization

Methods

a) Focus groups, interviews and surveys.
b) Surveys and outcome measures, including the Milestones of Recovery Scale (MORS) or another culturally competent measure will be conducted at intake, every 6 months and at discharge.
c) Two annual focus groups will be conducted
d) Data will be entered into contracted data bases provided by University of California, San Diego (UCSD) and will be analyzed by the UCSD research team

7. Contracting

All contracts are handled through San Diego County's Department of Purchasing and Contracting (DPC), which processes more than $1 billion in public purchases and contracts each year. The County posts its requirements for goods and services on BuyNet, an online public bidding system. Procurements will normally be posted on BuyNet under formal Request for Proposal (RFP) solicitations. The department's aim is sound procurement processes to acquire the highest quality goods and services at the best price.

Quality and regulatory compliance elements are included in each contract, specific to the funding source and purpose of the service. Proposals are selected in part on the basis of the offeror's plan to achieve best possible quality and compliance with all relevant regulations. A Contract Officer's Representative (COR) with Behavioral Health Services assumes responsibility for ongoing monitoring of the contract for compliance and outcomes, working with the DPC. Monitoring includes regular site visits, review of documentation, and oversight of applicable laws and regulations.

Contractors will have a dedicated Program Monitor from Behavioral Health Services who will develop a contract monitoring plan containing activities that will be conducted each year on their Statement of Work (SOW). Monthly Program Monitor meetings are routine.

There will be a minimum of four (4) monitoring activities per contract year, including a minimum of one (1) site visit, with subsequent visits, as needed, if identified issues have not been resolved.

Monthly COR meetings and site visit activities include but are not limited to deliverables review, technical assistance and consultation, review of fiscal and claim documentation and annual inventory update, emergency planning documentation, corrective action plans, discussion of strengths and weaknesses of contractor's deliverable outcomes.

There will be monthly review of SOW contract deliverables to determine contractor's performance in meeting contract objectives, review contractor exclusion/debarment/Medi-Cal Sanctions lists employee review process as well as a minimum of one (1) in depth invoice review annually.

Additional Information for Regulatory Requirements

1. Certifications

Board of Supervisors (BOS) authorization was requested on by 3/21/2017. Certification from the Behavioral Health Director will be included, Behavioral Health Services will provide Annual Revenue and Expenditure Reports as requested, and documentation will be provided by the County's PEI and CSS allocation.

2. Community Program Planning

Twelve (12) community forums were conducted county-wide to get community input and feedback regarding the Innovative project. The Older Adult, Adult and Children, Family and Youth Councils were also solicited for input regarding the community's need. Additionally, a Native American community dialogue was conducted to understand the needs of their community. After ideas for the Innovation Project was solidified, community members also participated in "conversation cafes" to discuss the proposed project and given opportunity to provide feedback on components needed.

3. Primary Purpose

Increased access and utilization of culturally competent mental health services to Native Americans in rural San Diego.

4. MHSA Innovative Project Category

Makes a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community

5. Population

The ROAM program aims to serve approximately 60 to 70 individuals per unit who will receive ongoing services on an annual basis with a total of approximately 120 to 140 individuals receiving ongoing mental health services from both units. An additional estimate of 300 individuals will be screened for services per unit, with an approximate 600 individuals projected to be screened annually for both units. The ROAM program will target children and youth who have severe emotional conditions and TAY, adults, and older adults with a serious mental illness who may also have co-occurring substance use disorders.

6. MHSA General Standards

a) Community Collaboration

Collaborations will include the Southern California Tribal Chairmen's Association, Indian Health Council, Southern Indian Health Council and other partners in the Dreamweaver Consortium to ensure program's outcomes and goals are aligned with theirs as well as increase services to their constituents.

b) Cultural Competency

Contractor shall recruit, retain and employ Native American individuals and individuals from rural areas. Service providers with Native American experience will be sought, and all contracted staff will be required to participate in culturally competent training specific to Native Americans, to advance working knowledge and complimentary treatment practices with Native American communities. Service providers will embed in the treatment team cultural brokers and engage community leaders (e.g. tribal elders, healers) to build meaningful trusting relationships as well as build on connections previously established by the Dreamweaver Consortium. Culturally competent practices such as complimentary traditional healing practices will be incorporated into treatment and services. As defined in

CCR, Title 9, Section 3200.100, this program demonstrates cultural competency and capacity to reduce disparities in access to mental health services to improve mental health outcomes and quality of life improvement.

c) Client-Driven

Services will be culturally competent, client-centered and clients will be the driver of their treatment plans and services.

d) Family-Driven

Family participation, involvement and collaboration will be sought to increase clients' support network to improve mental health outcomes.

e) Wellness, Recovery, and Resilience-Focused

Program aims to promote wellness and recovery within the Native American and rural populations focusing on mental health, client and families' resiliency to engage in treatment towards the goal of increased stability and ability to have productive lives.

f) Integrated Service Experience for Clients and Families

Providers will provide treatment and services in collaboration with the family with the clients consent to increase support and wellness, and use complimentary culturally competent healing practices to treat the person holistically within a spiritual, mental and physical health approach.

7. Continuity of Care for Individuals with Serious Mental Illness

Individuals enrolled in the program will receive an array of mental health services (described previously). The goal is to engage and provide clients with a different experience of the mental health system to increase their ability to participate in treatment with the goal of clinical stability. It is the intent of this program to continue pending successful outcomes and availability of funding. If the County is not able to continue with this program, Behavioral Health Services (BHS) will ensure clients are linked to the nearest Behavioral Health Services programs for continued mental health services. These may include linkages to Community Health Clinics, Indian Health Centers or BHS providers in the county.

8. INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement

Focus groups with the Native American population will be conducted to evaluate ongoing the ROAM program. Native American culture brokers will be sought to inform the evaluation team on the best approach to conduct the focus groups. Traditional cultures have a narrative style of communicating, telling a story to get to the point of interest. This may be useful with the Native American community. Short qualitative surveys or interviews about wellness or what has been helpful in an ethnographic style may be considered. BHS will seek the assistance of established Tribal Leaders, Elders and/or Culture Brokers to assist in the development of the evaluation.

9. Deciding Whether and How to Continue the Project Without INN Funds

The County will evaluate and determine if the program will be continued with another funding source

based on the program's outcomes and achievements demonstrated in the monitoring plan and evaluation results. All efforts will be made to ensure clients receiving treatment will be connected to outpatient mental health services as described in item 7 above.

10. Communication and Dissemination Plan

a) Information regarding the program, including outcomes, will be shared with stakeholders via the Behavioral Health Advisory Board, the Adult Council, Children's Council, Older Adult Council, TAY Council, Housing Council, the Cultural Competent Resource Team and other pertinent community meetings, presentations to various programs/service providers and conferences.

b) Forums will also be held with Southern California Tribal Chairmen's Association, Indian Health Council, Southern Indian Health Council and other Dreamweaver Consortium members and their constituents as well as at specific Tribal Council meetings at the designated Reservations or Native American community gatherings.

c) Program participants will be given the opportunity to share their experiences at stakeholder meetings, community forums and presentations to other services providers and conferences.

Keywords and phrases for the program include: Mental Health Mobile Unit, Native Americans Mental Health, Roaming Outpatient Access Mobile and Behavioral Health Mobile Unit.

11. Timeline

a) Total timeframe (duration) of the INN Project: 4 Years, 6 Months

b) Expected start date and end date: January, 2018 Start Date June, 2022 End Date

c) Timeline that specifies key activities and milestones

i. January 1, 2018 – June 30, 2018: Start Up period to include: identifying appropriate mobile units and build out, hiring or staff, meetings to build relationships and request input from Native American leaders and elders on the implementation of ROAM, develop ROAM Steering Committee, culturally competent training.

ii. July 1, 2018 to December 31, 2018: Begin treatment services and meetings with ROAM Steering Committee to determine evaluation approach and inform on ROAM progress. Monthly meetings to be held to include Program Monitor, evaluation provided thereafter.

iii. Monthly reports submitted and first annual report will be provided Fall 2019.

12. INN Project Budget and Source of Expenditures

Each full ROAM team will consist of 0.5 FTE Medical Doctor (dual board certified), 0.5 FTE registered nurse, 1 FTE Licensed Mental Health Clinician (dual filled as Program Manager), 1 FTE Peer Support Specialist (dual filled as driver), 1 FTE Family Support Specialist (dual filled as driver), 1 FTE cultural broker, and 1 FTE admin support/medical records. See below for estimated personnel, operating and indirect costs per each full team.

Position	Hourly Rate	Annual Salary (S)	Benefits (25% of S)	Operating (30% of S+B)	Indirect (15% of	**Fully Loaded**
Registered Nurse	$40.00	$41,600.00	$10,400.00	$15,600.00	$10,140.00	$77,740.00
LMCH/Program Manager	$35.00	$72,800.00	$18,200.00	$27,300.00	$17,745.00	$136,045.00
Case Manager	$24.00	$49,920.00	$12,480.00	$18,720.00	$12,168.00	$93,288.00
Peer Support Specialist/Driver	$20.00	$41,600.00	$10,400.00	$15,600.00	$10,140.00	$77,740.00
Peer Support Specialist/Driver	$20.00	$41,600.00	$10,400.00	$15,600.00	$10,140.00	$77,740.00
Cultural Broker	$25.00	$52,000.00	$13,000.00	$19,500.00	$12,675.00	$97,175.00
Admin/medical records	$22.00	$45,760.00	$11,440.00	$17,160.00	$11,154.00	$85,514.00
MD	$225.00	$234,000.00				$234,000.00
Half Year (per mobile clinic):		$332,800.00		$64,740.00	$42,081.00	**$439,621.00**
Full Year (per mobile clinic):		$665,600.00		$129,480.00	$84,162.00	**$879,242.00**

Additional Costs (per mobile clinic):

Non Recurring Costs (mobile vehicle):	$240,000.00
Half Year Evaluation (5%):	$21,981.05
Full Year Evaluation (5%):	$43,962.10
Total full year per mobile clinic:	**$963,583.10**
Total full year for 2 mobile clinics:	**$1,846,408.20**

Total Annual Cost for Both Mobile Clinics

Cycle 4 INN 20 ROAM						
Innovative Project Budget by FISCAL YEAR (FY)						
BUDGET TOTALS	**FY 17/18 (Half)**	**FY 18/19**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**TOTAL**
Personnel	665,600.00	1,331,200.00	1,331,200.00	1,331,200.00	1,331,200.00	5,990,400.00
Direct Costs						
Indirect Costs	84,162.00	168,324.00	168,324.00	168,324.00	168,324.00	757,458.00
Operating Costs	129,480.00	258,960.00	258,960.00	258,960.00	258,960.00	1,165,320.00
Non Recurring Costs	480,000.00					480,000.00
Other Expenditures						
INNOVATION BUDGET						
Evaluation 5%	43,962.10	87,924.20	87,924.20	87,924.20	87,924.20	395,658.90
TOTAL	**1,403,204.10**	**1,846,408.20**	**1,846,408.20**	**1,846,408.20**	**1,846,408.20**	**8,788,836.90**

Innovative Project Plan Description

County: San Diego County **Total Funding Request**: $6,155,624

Project Name: ReST Recuperative Services Treatment **Duration:** Jan 1, 2018 – June 30, 2022

Project Overview

1. Primary Problem

In San Diego County, there are a subset of individuals who have severe mental illness (SMI), are homeless, and who utilize acute/emergency settings (emergency departments (ED), Short Term Acute Residential Treatment (START), Psychiatric Emergency Response Team (PERT), emergency psychiatric unit (EPU), and jail mental health services), but are not otherwise connected to outpatient mental health services – these individuals are considered "unconnected." Transitional Age Youth (TAY; 18-25 y/o) with SMI are particularly more vulnerable to homelessness and incarceration than their non-SMI counterparts. Multiple factors including inability to complete high school, lack of employment and individual living skills are compounded by the TAY's mental health symptoms.

San Diego County proposes to decrease the number of homeless and unconnected TAY to prevent these individuals from inappropriately returning to acute/emergency mental health services (ED, START, PERT, EPU and jail mental health services) by providing them with recuperative and habilitative mental health care. Individuals enrolled in ReST will be engaged in habilitation services and be connected to appropriate levels of care and housing to support ongoing recovery and wellness.

Background. According to the Office of National Drug Control Policy, approximately 30 percent of the chronically homeless population has a serious mental illness (SMI) that creates barriers to accessing and maintaining stable housing. These barriers could include the inability to participate in essential activities such as self-care, completing education, maintaining employment and household management (National Coalition for the Homeless, 2009). Individuals with SMI may also have difficulty maintaining social relationships which leads to social isolation, often times due to active symptoms and stigma of having a mental illness (Linz & Strum, 2013). Conversely, lack of housing options (short-term, bridge housing and permanent supportive housing) exacerbates mental health conditions and inhibits recovery and wellness. Additionally, the homeless in general, and the homeless with SMI, in particular, are more at risk for substance usage. These individuals may turn to substance usage as a way to cope with their circumstance of being homeless (National Coalition for the Homeless, 2009) and individuals with SMI may use substances to self-medicate their symptoms (Dualdiagnosis.org). Homelessness also affects incarceration rates. A national survey study found that 15% of inmates were homeless prior to incarceration, a rate that is 7.3 to 11.5 times the standardized estimate of 1.36% to 2.03% in the U.S. adult general population (Greenberg & Rosenheck, 2008). Furthermore, subgroups within the homeless population including individuals with SMI, veterans, and youth are particularly vulnerable to incarceration (National Health Care for the Homeless Council, 2013).

The Bazelon Center for Mental Health Law indicated that TAY with SMI are three times more likely to be involved in criminal activity than TAY without mental illness and have higher rates of substance abuse than any other age groups with mental illness. In 2016, San Diego's Point In Time count indicated there

were a total of 685 TAY who were homeless, with 459 TAY indicating that they were unsheltered. Additionally, the count indicated that 22.8% of homeless youth had mental health issues and 14.6% had substance abuse (2016 WeALLCount). In fiscal year 15/16, there were 196 unconnected TAY who self-identified as homeless that accessed acute/emergency mental health services. Among these individuals, there has been repeated inappropriate utilization of these acute/emergency mental health services due to the fact that they are unconnected to outpatient mental health services.

2. What Has Been Done Elsewhere To Address Your Primary Problem?

Recuperative Services. Traditionally in the medical field, recuperative care centers exist to assist clients discharged from an acute hospital who are homeless to continue their recovery. There are a large number of recuperative care centers around the U.S. that treat primarily physical health needs after an acute stay at a hospital. Recuperative care centers in the medical field have been proven effective in decreasing the number of hospital readmissions. In an observational study of Boston's Respite Care, Kertesz et al. (2009) analyzed three years' worth of administrative data and found that respite care significantly reduced the likelihood of a homeless patient being readmitted to a hospital within 90 days of discharge compared to those who were discharged to their own care or other planned care. While existing recuperative care centers will provide holistic care and may address issues of mental health and substance usage, in order to access these recuperative care centers, clients must have a primary medical issue. There appears to be a lack of recuperative centers specifically for individuals with SMI.

Arizona's Restart program appears to be the only program in the United States that provides short-term housing to individuals with SMI transitioning from hospitals and jails back to the community. The program's goal is "finding longer term housing, either through reconnection with family, Supportive Community Housing, or preparation for a treatment-oriented housing setting. Our teams also help members maintain their wellness through group interactions and 1:1 support with living skills, transportation, personal care support, and medication reminders." However, Arizona's Restart program is not focused on services or habilitation, but rather on housing.

Finding. The majority of recuperative services target clients with primary medical and physical health needs. These recuperative care centers have been effective in preventing hospital readmissions. There does not appear to be any programs that provide recuperative and habilitative services to clients with primary mental health needs. One program, the Arizona's Restart program, provides short term housing services (30-days) to persons with SMI who have transitioned from the hospital or jail setting; however, intensive recuperative and habilitative services are not provided akin to those in the medical recuperative care centers. Services provided at Arizona's Restart program appear to be a bridge to housing with supports and are focused on locating housing for its clients.

3. The Proposed Project

The proposed Recuperative Services Treatment (ReST) project is envisioned and designed to provide recuperative and habilitative mental health care services and housing support in an open housing development or residential site similar to Board and Care buildings for TAY clients. The target population are TAY clients with SMI who 1) require habilitative services (e.g. managing symptoms, learning activities of daily living) post-discharge from acute care settings, 2) are homeless or at-risk of

homelessness, 3) are unconnected to mental health treatment, and 4) have repeated utilization of inappropriate levels of care (e.g. acute/emergency care settings).

ReST will be an Enhanced Strength Based Case Management program with mental health services co-located at the housing site. Clients will be referred through acute/emergency settings (e.g. ED, START, PERT, EPU, jail mental health settings) and meet the criteria listed above.

The recuperative-care site will be a "home-like" environment in design and have a live-in resident manager as well as office space for staff, such as a Program Manager, Housing Specialist, Licensed Mental Health Clinician, Case Manager with AOD certification, Peer Support Specialists, and part time psychiatric consult and nurse practitioner, live-in housing manager, and cook. The program will provide screening, behavioral health assessment, individual and group counseling, medication management, case management, care coordination, peer and family support services, linkages to permanent housing and other needed resources. Medication Assisted Treatment (MAT) services will be available for individuals with a co-occurring substance usage disorder.

Although mental health services will be offered on-site, this program design is not that of a residential treatment facility. Clients will not "complete" treatment and will not graduate to a "step down" program. Instead, the services provided through ReST will be geared towards providing a different experience with mental health providers and to teach habilitative skills to engage and connect the TAY clients to ongoing appropriate levels of care, link them to housing, and provide them with enough skills (e.g. managing symptoms, activities of daily living, educational or employment skills) so that they will no longer inappropriately utilize acute/emergency care settings. Additionally, there will also be a "mentorship" component in which Peer Support Specialists will continue to work with clients after they have left ReST to ensure continuity and provide support 30-60 days post-completion of ReST.

4. Innovative Components

ReST is an adaptation from both the medical field's recuperative care centers that have been shown to reduce readmission to acute care settings and adds the following innovative approaches:

- The main innovation component of ReST is providing habilitative mental health services. Habilitation is defined as "the process of supplying a person with the means to develop maximum independence in activities of daily living (ADL) through education and/or treatment" (Mosby's Medical Dictionary, 2009). This habilitative component is adapted from the medical field's recuperative services. Clients will have time to stabilize, learn how to cope with their symptoms, learn ADL skills, and learn ways to access services appropriately.
- While ReST is not a residential treatment facility, it will have mental health services co-located onsite. The co-location of services is geared at providing clients with a different experience of mental health providers with the goal of successfully linking the clients to ongoing treatment, housing and preventing future, and inappropriate use of acute/emergency care settings.
- San Diego's proposed ReST project differs from the Arizona's Restart program by targeting a specific age group (18-25 y/o) with the addition of co-location of recuperative and habilitative mental health services and MAT services which will also be provided to clients with co-occurring disorders.

- Using MAT to assist and support sobriety and recovery for individuals with co-occurring disorders. Untreated mental health conditions are often masked by the use of alcohol or other drugs in the form of self-medication in which clients medicate mental health symptoms by using alcohol and drugs (Foundations Recovery Network).
- Clients will have the opportunity for ongoing mentorship with ReST Peer Support Specialists for up to 60 days after leaving ReST to provide any support while client transitions to more permanent outpatient treatment.

5. Learning Goals / Project Aims

1) Decrease TAY's inappropriate utilization of acute care services and/or returning to jail, 2) Increase TAY's ability to manage their symptoms and improve their level of functioning and ability to live independently, and 3) Increase connection with an ongoing outpatient mental health program.

a) Does the use of a habilitation model demonstrate success in penetration and retention of TAY who are unconnected to treatment and have repeatedly utilize acute care, STARTs, EDs, PERT, EPU and jail mental health services?
b) Do TAY enrolled in ReST demonstrate an increase in engagement with treatment due to the co-location of mental health and support services?
c) Does ReST impact acute/emergency care (START, ED, PERT, EPU, and jail mental health services) recidivism?
d) Do TAY enrolled in ReST demonstrate an improvement of their symptoms or mental health condition?
e) Do TAY enrolled in ReST demonstrate an ability to stay connected to treatment during and post discharge?
f) Do TAY enrolled in ReST demonstrate a reduction of stigma associated with their symptoms or mental health condition?
g) Do TAY enrolled in ReST demonstrate an increase in knowledge of how to access behavioral health services and housing supports?

6. Evaluation of Learning Plan

To determine whether the learning goals listed above are met, the following approaches will be utilized. Some approaches will be universal to all of the learning goals, while others will be specific to particular learning goals.

Target participants are TAY with inappropriate and high utilization of acute care services. Behavioral Health Services Data from FY 15/16 (C0-19 Report) for unconnected clients will be analyzed to determine the TAY population that will be the focus of attention for the ReST program.

<u>Data to be Collected</u>

a) Demographic data, including but not limited to age, race, ethnicity, gender, sexuality, disability, veteran status, diagnosis, and primary language will be collected.
b) Client outcomes such as engagement in treatment, increased understanding of mental health, attaining educational and employment goals, increase in socialization, decrease in

symptoms and negative behaviors, decrease in homelessness, and decrease in inappropriate and frequent utilization of acute/emergency care services.

c) The number of TAY returned to acute care hospitals, START, EPU, PERT and/or jail setting while enrolled in program will be tracked as well as information regarding number of clients returning to acute care hospitals, START, EPU, PERT and/or jail setting within 90 days, at 6 months and 12 months post-discharge from program.

Methods

a) One major tracking mechanism includes the usage of Cerner Community Behavioral Health (CCBH), an electronic health record system, which tracks demographics, diagnosis, and episodes in different levels of care including acute care hospitalization, START, EPU, PERT and jail mental health services. Baseline data will be collected for the previous 12-month and 24 month data from C0-19 report.
b) Current collaboration with the Sheriff and Probation will facilitate access to arrest data.
c) Focus groups, interviews and surveys will be administered to TAY clients Pre and Post discharge from the program. TAY clients will be administered the Milestones of Recovery Scale (MORS) or other TAY specific scales to determine level of care needed at intake, 30 days, 60 days and upon discharge.
d) Data will be analyzed and reported by the University of California, San Diego (UCSD). Other data collection methods will be used to determine engagement in treatment, reduction of stigma, and client satisfaction will be obtained via interviews and/or surveys that will be developed and analyzed by the UCSD research team.

7. Contracting

All contracts are handled through San Diego County's Department of Purchasing and Contracting (DPC), which processes more than $1 billion in public purchases and contracts each year. The County posts its requirements for goods and services on BuyNet, an online public bidding system. Procurements will normally be posted on BuyNet under formal Request for Proposal (RFP) solicitations. The department's aim is sound procurement processes to acquire the highest quality goods and services at the best price.

Quality and regulatory compliance elements are included in each contract, specific to the funding source and purpose of the service. Proposals are selected in part on the basis of the offeror's plan to achieve best possible quality and compliance with all relevant regulations. A Contract Officer's Representative (COR) with Behavioral Health Services assumes responsibility for ongoing monitoring of the contract for compliance and outcomes, working with the DPC. Monitoring includes regular site visits, review of documentation, and oversight of applicable laws and regulations.

Contractors will have a dedicated Program Monitor from Behavioral Health Services who will develop a contract monitoring plan containing activities that will be conducted each year on their Statement of Work (SOW). Monthly Program Monitor meetings are routine.

There will be a minimum of four (4) monitoring activities per contract year, including a minimum of one (1) site visit, with subsequent visits, as needed, if identified issues have not been resolved.

Monthly COR meetings and site visit activities include but are not limited to deliverables review, technical assistance and consultation, review of fiscal and claim documentation and annual inventory update, emergency planning documentation, corrective action plans, discussion of strengths and weaknesses of contractor's deliverable outcomes.

There will be monthly review of SOW contract deliverables to determine contractor's performance in meeting contract objectives, review contractor exclusion/debarment/Medi-Cal Sanctions lists employee review process as well as a minimum of one (1) in depth invoice reviews annually.

Additional Information for Regulatory Requirements

1. **Certifications**

Board of Supervisors (BOS) authorization will be requested by 3/21/2017. Certification from the Behavioral Health Director will be included, Behavioral Health Services will provide Annual Revenue and Expenditure Reports as requested, and documentation will be provided by the County's PEI and CSS allocation.

2. **Community Program Planning**

Twelve (12) community forums were conducted county-wide to get community input and feedback regarding the Innovative project. The Older Adult, Adult and Children, Family and Youth Councils were also solicited for input regarding the community's need. Using the input from stakeholders, Behavioral Health Services (BHS) proposed preliminary ideas for the Innovation Project in "conversation cafes" in which community members participated in discussions around the proposed project and given the opportunity to provide feedback on components needed.

3. **Primary Purpose**

a) Increased access to mental health services to underserved groups

4. **MHSA Innovative Project Category**

a) Introduces a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting.

5. **Population**

The ReST Program intends to serve 15-17 individuals at any given time with each individual residing in the program for up to 90 days. Once clients have completed the program, they will continue to be supported through a mentorship program to ensure connection and sustained participation with ongoing outpatient services. Based on the capacity of the program, the projected number of clients served annually will be between 48-60 individuals.

The target population are TAY clients with SMI who 1) require habilitative services (e.g. managing symptoms, learning activities of daily living) post-discharge from acute care settings, 2) are homeless or at-risk of homelessness, 3) are unconnected to mental health treatment, and 4) have repeated utilization of inappropriate levels of care (e.g. acute/emergency care settings). The ReST program is

inclusive of any gender identity, race, ethnicity, sexual orientation or language.

6. MHSA General Standards

a) Community Collaboration

For community collaboration, local LPS hospitals, STARTs, jail mental health services, EDs, EPU, PERT, Sheriff and Probation Departments will be consulted and partnered with to ensure the most appropriate TAY individuals are referred and linked to the program.

b) Cultural Competency

As defined in the CCR, Title 9, Section 3200.100, this program demonstrates cultural competency and capacity to reduce disparities in access to mental health services to improve outcomes. To achieve this, service providers will be required to 1) participate in trauma informed care, 2) have working knowledge of TAY population and developmental needs, 3) have knowledge about the culture of homelessness, and 4) how to access an array of appropriate housing options for TAY.

c) Client-Driven

To ensure that services are client driven, the program will focus on the clients' goals and treatment planning will be a collaborative process between the clients and service providers. Clients' feedback and participation will be utilized to evaluate the program's outcomes and implement new policies, procedures and services, if needed.

d) Family-Driven

The program will also include clients' families (or other support network) with client consent to assist in the treatment planning, engagement of client and post-discharge connectedness to outpatient treatment so that services. Program can also assist clients in re-engaging with their families of origin if this is desired by the client.

e) Wellness, Recovery, and Resilience-Focused

This program strives to increase clients' ability to manage their symptoms and level of functioning through habilitative and recuperative mental health services to facilitate recovery and wellness post discharge from an acute setting. An Enhanced Strength Based Model of service will be the cornerstone of services to increase resiliency and recovery; thus decreasing episodes of in acute care settings or jail post discharge from the program.

f) Integrated Service Experience for Clients and Families

Program will provide care coordination with other specialties (physical health, substance use programs) to provide a full range of services/resources to increase the clients' ability to move forward towards their goals of wellness and recovery.

7. Continuity of Care for Individuals with Serious Mental Illness

The program by design is a short term, up to 90 day program aimed at providing recuperative and habilitative mental health services with co-location of service providers. TAY will be linked to

appropriate levels of care (family health centers, outpatient mental health services, alcohol and drug services, Full Service Partnerships) for mental health services while the client is at ReST. Clients will also be linked to an array of housing services to ensure continuity of care once client is discharge from the program. The goal of ReST is to provide clients with a different experience with the mental health system to increase their connection to ongoing care. The intent is to continue the program pending successful outcomes and availability of funds. If the County is not able to continue with the program, clients will be referred to appropriate levels of care services directly from the acute care setting.

8. INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement.

a) Cultural Competence

Focus groups with the TAY population will be conducted. TAY Council and current TAY treatment providers will be also be consulted to address issues that are unique to the TAY population (e.g. stage of development, experience of first psychotic break).

b) Stakeholder participation

The TAY Council is a key stakeholder for this project. Through the TAY Council, a steering committee will be created to guide the program and development of its evaluation.

9. Deciding Whether and How to Continue the Project Without INN Funds

Part of the continual monitoring and evaluation of program's outcomes and achievements through the monitoring plan and based on lessons learned, the County will decide if the program will convert into another funding source. If the County is not able to continue with the program, clients enrolled in the program will be linked to other outpatient mental health services or to mental health services in primary care settings for continuation of services.

10. Communication and Dissemination Plan

To disseminate information to stakeholders, information regarding the program, including outcomes, will be shared via the Behavioral Health Advisory Board, Adult Council, Children's Council, TAY Council, Housing Council, the Cultural Competent Resource Team, Probation AB109 bi-monthly meetings and other pertinent community meetings, presentations to various programs/service providers and conferences. Program participants will also be given the opportunity to participate and share their experiences at stakeholder meetings, community forums and presentations to other services providers and/or conferences.

The following are keywords or phrases for this project: Mental Health Recuperative Care, Mental Health Habilitative Care, Mental Health Aftercare, Recuperative Bridge Housing, and Behavioral Health Recuperative Care

11. Timeline

a) Timeframe (duration) of the INN Project: 4 Years, 6 Months

b) Expected start date and end date: January 2018 Start Date; June 2022 End Date

Timeline that specifies key activities and milestones

I. January 1, 2018 – June 30, 2018: Start-up period to include identifying appropriate housing or residential site. Identify and meet with TAY Steering Committee to determine evaluation approach.

II. July 1, 2018 – December 31, 2018: Begin habilitative treatment services, begin evaluation design and development. Monthly TAY Steering Committee meetings begin with participation of BHS program monitor and UCSD research evaluators. Monthly meetings to be held to include Program Monitor, evaluation provided thereafter.

III. Monthly reports submitted and first annual report will be provided Fall 2019.

12) INN Project Budget and Source of Expenditures

The ReST team will consist of 1 FTE Program Manager, 1 FTE Licensed MH clinician, 1 FTE Case Manager with AOD certification, 1 FTE Housing Specialist, 2 FTE Peer Support Specialists, 1 FTE admin support/medical records, 1 FTE housing manager, 1 FTE cook, 0.5 FTE nurse practitioner, and 0.1 FTE psychiatric consult. See below for estimated personnel, operating and indirect costs.

* Operating costs include flex funds, maintenance, utilities, supplies, transportation, master-lease etc.

Position	Hourly Rate	Annual Salary (S)	Benefits (25% of S)	Operating (30% of S+B)	Indirect (15% of S+B+O)	**Fully Loaded**
Program Manager	$33.00	$68,640.00	$17,160.00	$25,740.00	$16,731.00	$128,271.00
Housing Specialist	$22.00	$45,760.00	$11,440.00	$17,160.00	$2,574.00	$76,934.00
FTE NP	$59.00	$61,360.00	$15,340.00	$23,010.00	$3,451.50	$103,161.50
FTE LMHC	$27.00	$56,160.00	$14,040.00	$21,060.00	$3,159.00	$94,419.00
FTE CM with AOD cert	$24.00	$49,920.00	$12,480.00	$18,720.00	$2,808.00	$83,928.00
FTE PSS	$18.00	$37,440.00	$9,360.00	$14,040.00	$2,106.00	$62,946.00
FTC PSS	$18.00	$37,440.00	$9,360.00	$14,040.00	$2,106.00	$62,946.00
Admin/medical records	$20.00	$41,600.00	$10,400.00	$15,600.00	$2,340.00	$69,940.00
Cook	$15.00	$31,200.00	$7,800.00	$11,700.00	$1,755.00	$52,455.00
Live-in Housing Manager	$24.50	$50,960.00	$12,740.00	$19,110.00	$2,866.50	$85,676.50
Psychiatric Consult	$200.00	$41,600.00				$41,600.00
Half Year:		$321,100.00		$90,090.00	$19,948.50	**$431,138.50**
Full Year:		$642,200.00		$180,180.00	$39,897.00	**$862,277.00**

Additional Costs:

Non Recurring Costs:		$26,000.00
Annual master lease for 20 units:		$360,000.00
Annual food budget at $15.8/day/client:		$75,000.00
Half Year Evaluation (5%):		$32,431.93
Full Year Evaluation (5%):		$64,863.85
	Half Year Total:	**$707,070.43**
	Full Year Total:	**$1,362,140.85**

Cycle 4 INN 21 ReST						
Innovative Project Budget by FISCAL YEAR (FY)						
BUDGET TOTALS	**FY 17/18 (Half)**	**FY 18/19**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**TOTAL**
Personnel	321,100.00	642,200.00	642,200.00	642,200.00	642,200.00	2,889,900.00
Direct Costs						
Indirect Costs	19,948.50	39,897.00	39,897.00	39,897.00	39,897.00	179,536.50
Operating Costs	307,590.00	615,180.00	615,180.00	615,180.00	615,180.00	2,768,310.00
Non Recurring Costs	26,000.00					26,000.00
Other Expenditures						
INNOVATION BUDGET						
Evaluation 5%	32,431.93	64,863.85	64,863.85	64,853.85	64,863.85	291,877.33
TOTAL	**707,070.43**	**1,362,140.85**	**1,362,140.85**	**1,362,130.85**	**1,362,140.85**	**6,155,623.83**

County: San Diego County **Total Funding Request**: $8,836,362

Project Name: Medication Clinic **Duration:** July 1, 2018 – December 31, 2022

Project Overview

1. Primary Problem

The County of San Diego has approximately 3.3 million people, of which 750,000 are under the age of 18. The rate of significant mental illness for children and youth is conservatively estimated at 10%, whereby 75,000 are at risk for mental health problems that interfere with their development, school function, social relationships, and ability to succeed in our society.

The County of San Diego Behavioral Health Services Division serves approximately 18,000 children and youth per year. Its current outpatient model provides for 13 sessions per person, with the option of an additional cycle of 13 sessions if a utilization review process deems the additional sessions necessary. The services offered are based on a Child Guidance Clinic model of individual therapy, conjoint therapy with caregivers, psychiatric medication assessments when indicated, medication follow up services, and group therapy in some locations, and case management for high basic needs families. Over the years, Therapeutic Behavioral Services, Wraparound Services, and Full Service Partnerships have been added to the service mix. There is access to emergency services through the Emergency Screening Unit, North County Behavioral Walk-In Clinic, and the Psychiatric Emergency Response Teams (affiliated with law enforcement). The in-patient psychiatric care is provided at 3 local psychiatric units.

This system of services has provided excellent, well regarded and highly rated services for children, youth and families who are able to access this system. This system works well for those who have episodic, short-term mental health problems that can be managed with psychotherapy and medication treatments.

Some of these young people find that they can live stable lives with the assistance of psychotropic medications after receiving psychotherapy services, but our system of care through the organization provider network (Community Based Organizations) has limited capacity to provide medication-only services. Currently, these youth are referred to primary care doctors, fee-for-service psychiatrists or federally qualified health clinics for ongoing psychotropic medication support. Conditions that may require ongoing medication support include Attention Deficit Hyperactivity Disorder (ADHD), Generalized Anxiety Disorder, Panic Disorder, Major Depression, and others. For children and youth with complex combinations of mental health problems (or with recognized complex mental disorders like complex Post Traumatic Stress Disorder, Bipolar Disorder, Schizophrenia, Autism with aggression, ADHD plus mood dysregulation) can be difficult to find a primary care doctor prepared to manage the medication treatment aspect of their care.

In addition, there are also children who are seen in other locations i.e. primary care medical offices, specialty medical care offices, who do not receive specialty mental health care. These children may have complex medical illnesses and condition such as asthma, cancer, diabetes, gastrointestinal illnesses, genetic abnormalities and also have mental health needs. At present, these individuals are not

receiving coordinated behavioral health services in the same location and in collaboration with their medical treatment.

This proposal attempts to address some of the above issues involving ongoing medication support for children and youth who continue to need medication services once their therapy sessions end.

2. What Has Been Done Elsewhere to Address Your Primary Problem?

We have done extensive literature review searches, conducted selected focus groups, interviewed with Pediatric and Child Psychiatry Professional Organizations (AAP and AACAP local and nationally) and the broader community forums during the development of our Psychiatric Consultation for Primary Care (beginning in 2010 and continuing through 2016) efforts. These efforts resulted in our current program called "Smart Care", which offers telephone consultation to primary care physicians treating both children and adults with mental health problems in the primary care locations. This is a successful program for relatively uncomplicated clinical cases, but is not sufficient for treating long term, somewhat chronic, cases or for complex medical and mental health cases. The Washington State PAL program and the Massachusetts Child and Adolescent Psychiatric Access program have found the same situation where consultation is helpful, but not sufficient for complex mental health problems or for complex medical illness and mental health problems.

We have not found a similar program in California nor in the United States that has the flexibility, clinical expertise, and creativity to solve these difficulties.

3. The Proposed Project

The proposed project will establish a Psychotropic Medication Clinic staffed by expert child and adolescent psychiatrists, case manager clinicians, psychiatric nurses, and a program manager to be implemented by a Community Based Organization under a contract agreement with the County of San Diego. These clinicians will provide medication support services to children and youth who have mental health problems that require medication treatment to support their function, safety, and reduce suffering so that they can participate in school, community activities, and have a rich home life. These psychiatrists will be mostly in one location, but may also provide care in multiple settings.

a) Telepsychiatry to two (2) locations per region (6 regions of the county- total of 12 sites) potentially in conjunction with primary care medical offices.
b) On-site psychiatric care in a Specialty Medical Office of Developmental and Behavioral Pediatricians who currently see children with complex medical problems.
c) On-site, office-based, psychiatric care for medication support at an office centrally located in the County. This service will not be time limited, and will be provided as long as is needed by the client (eligibility will continue until the child/youth is 18 years of age.

In addition, other services which are not currently available in San Diego County as a part of a treatment clinic, will be provided. These services include:

a) Psycho-educational presentations about mental health problems, treatments, resources, medication side effects and effects. These presentations will be in the evenings and will offer on-site child care.

b) Resource fair for families- videos, books, pamphlets, website with resources and upcoming events.
c) Peer support groups- NAMI, ChADD
d) Consultation to school personnel, probation staff, child welfare staff, and primary care offices for those children and youth involved in multiple systems
e) Specialty Clinics for the medication management of Attention Deficit Hyperactivity Disorder and Anxiety Disorders

It is hoped that this clinic will be seen as a "Center for Child Psychiatry" in our county, both for children, youth and their families, but also other clinicians and community partners.

The Medication Clinic will be involved in the following approach specified in CCR, Title 9, Sect. 3910(a) will change several existing practices in mental health.

1. Providing specialty medication support services to children and youth who are discharged from their organization provider (Community Based Organization) yet have needs too complex for Primary Care Clinicians.
2. Provide coordinated and co-located access to care for children and youth who access primary care in Developmental Pediatricians' Offices due to having complex medical needs. Most medically complicated children (those who have serious illnesses with complicated treatment) do not seek Specialty Psychiatric Care in the way non-medically ill people do. This project allows them to receive this level of care that is more sophisticated and intense than that available from Developmental Behavioral Pediatricians.
3. Telepsychiatry to multiple locations in the County for children and youth who do not have or have not accessed Specialty Psychiatric Care due to geographical distance, cultural reluctance, stigma, fear, or socioeconomic concerns.
4. Address workforce shortages by exploring telepsychiatry with psychiatry groups who may be outside of San Diego County (External Quality Review recommendation from FY15/16 review).
5. Psychoeducational evening programs to families on relevant topics with on-site child care.
6. Resource Fairs for families to get videos, books, pamphlets and web-site access to information and resources.

We determined the need and best approach by holding multiple discussions with multiple different Organizational Provider (Community Based Organizations) personnel (Program Managers, Psychiatrists, Case Managers, Therapists), families approaching the youth's discharge date, pediatricians who were receiving referrals for children being discharged from organizational provider clinics, Developmental Behavioral Pediatricians, the Children Youth and Families System of Care (CYF-SOC) participants (annual planning and prioritizing meeting), the CYF-SOC Early Childhood Subcommittee members, the local American Academy of Pediatrics, and the San Diego Academy of Child and Adolescent Psychiatry. We also discussed the challenges such as discharges from organizational provider clinics, medically complicated children with mental health needs, clinics that lose their psychiatric consultants and have no replacement for long periods of time, with the local organization that oversees the fee-for-service Medi-Cal providers in terms of the availability of Psychiatrists on their panel.

4. **Innovative Components**

- On-site collaboration, psychiatric evaluations and treatment in Developmental Behavioral Pediatricians' office for medically complex youth
- Recognizes the value of longer-term, responsible psychiatric care for youth who have clinically stabilized but continue to require complex psychotropic medication regimens, particularly in light of recent legislative focus on psychotropic medication provision to Medi-Cal youth
- 12 Telepsychiatry sites in 6 regions for psychiatric consultation with efforts to place in a primary medical care office
- Psychoeducation programs at night for families, youth, other caregivers, educators on topics related to mental health problems, treatments, resources with available child care
- Resource fairs which provide access to books, articles, videos, pamphlets on relevant topics
- Consumer support meetings at the same location that services are provided (NAMI, ChADD, Bipolar Foundation)
- Temporary psychiatric coverage for programs that lose their psychiatric consultants and are having trouble recruiting
- Monitoring the medication treatments of children and youth who are not receiving services from an Organizational Provider Clinic

5. Learning Goals/Project Aims

The Project's main goals are to see if a Medication Clinic can serve as a specialty program for children and youth who have been clinically stabilized and who may require sophisticated psychiatric services sufficient to meet their ongoing complex prescribing needs. The main questions are:

a. Can an on-site psychiatrist work in close collaboration with Developmental Behavioral Pediatricians to provide integrated care to children and youth with complex medical and mental health problems?
   i. What does the working relationship need to be?
   ii. How will they communicate?
   iii. How can they safely provide intense medical and mental health care? Does this program intervention serve to better address interactions between psychotropic medications and medications provided for complex medical illness?
   iv. What are the health outcomes that each child and family seeks? Can this arrangement facilitate those outcomes (they will be different for each person and family)?

b. Can we potentiate the stability of youth by providing consistent, longer term relationships with a prescriber team?

c. Can we leverage psychiatrist outside our County via Telepsychiatry to expand our limited pool of prescribers available to serve our community's youth?

d. Can a stand-alone Medication Clinic be a stabilizing factor for children discharged from Organizational Provider Full Service Clinics and work with different schools, therapists, primary care physicians, and group homes in a collaborative and integrated manner?

i. Can this clinic be seen by its users (children, youth, caregivers, teachers, other helpers) as a helpful support? A source of information and resource?

6. Evaluation of Learning Plan

a) Target Participants: Youth with complex, comorbid medical and psychiatric needs. Youth who have clinically stabilized but continue to require complex psychotropic medication regimens. Education will target youth and families who utilized psychotropic medication as well as System of Care practitioners to increase the workforce understanding of aforementioned issues.

b) What data is to be collected? For this component the County of San Diego will be using evaluators from UCSD to assist with the development of measures, the data collection, and data analysis. The UCSD group has years of experience conducting System of Care assessments and implementation of change assessments.

c) The CYF-SOC presently completes a system of care evaluation and has a set of questions it uses. In collaboration with Developmental Behavioral Pediatricians, a questionnaire will be developed to identify the health outcome goals for each child seen, and then subsequently, a questionnaire to find out if those goals have been reached. Lastly, the medical and mental health participants will be asked to respond to a questionnaire about integration of effort, ease of working together, communication, ways the arrangement has improved care and ways the arrangement has hindered care.

7. Contracting

The County has significant experience developing Requests for Proposals, overseeing contracts, and evaluating outcomes. This is the 4th set of Innovation projects the County is developing. The contracts are overseen by Behavioral Health Services Contracting Officer Representatives (CORs) and the process of contracting is seen by The County of San Diego Department of Purchasing and Contracting.

Additional Information for Regulatory Requirements

1. Certifications

a. Adoption by County Board of Supervisors by date (TBD)
b. Certification by the County Behavioral Health Director
c. Certification by the County Mental Health Director and by the County Auditor-Controller
d. Documentation that the source of INN funds is 5% of the County's PEI allocation and 5% of the CSS allocation

2. Community Planning

a. Twelve (12) community forums were conducted County-wide to get community input and feedback regarding the Innovation project
b. The Older Adult, Adult and Children, Family and youth Council were also solicited for input regarding the community's need

c. After ideas for the Innovation Project was solidified, community members also participated in "conversation cafes" to discuss the proposed project and given opportunity to provide feedback on components needs

3. Primary Purpose

Increase access to specialized psychiatric services to underserved groups

4. MHSA Innovative Project Category

Introduces a new mental health practice of approach for children and youth consisting of psychiatric medication-only services provided via Telepsychiatry to multiple regions of the County, medication support services located in Special Needs Pediatric Clinics, and medication support services in a central office location provided to children and youth who completed psychotherapy but still have an ongoing need for medication treatment.

5. Population

a. Number Served: The estimated number of children and youth to be served by direct services is 100 in the Developmental and Behavioral Pediatrics office, 300 in the Telepsychiatry locations (approximately 25 children at each location), and 100 in the Medication Clinic itself. The average cost per person served is $3,800 per year (500 children/youth for $1,900,000).
b. Population is children/youth from approximately 3 to 21 years of age, who live anywhere in the County of San Diego, who are transitioning out of receiving Organizational Provider Mental Health services, or who have complex medical needs and are served by the Developmental Behavioral Pediatricians. There is no limit as to race, ethnicity, gender orientation, geographic location or language. The clinical and administrative data for these children and youth will be collected in the County of San Diego electronic medical record system so will be able to be gathered and reported.
c. Target Groups: It is one of the purposes of this project to meet the mental health needs of medically ill children. These children's eligibility for service will be that they have a medical illness, a mental health illness, a developmental disorder, or significant family stress and disorder. It is expected that the children will have at least two (2) of these qualifying characteristics and be seen in the Developmental Pediatrics office.

6. MHSA General Standards

a. Community Collaboration: The concept for this work plan was developed based on local stakeholder process for input on system needs over multiple years.
b. Cultural Competence: As defined in CCR, Title 9, Section 3200.100, this program demonstrates cultural competency and capacity to reduce disparities in access to mental health services to improve outcomes.
c. Client/Family Driven Mental Health System: This program includes the ongoing involvement of clients and family members in roles such as, but not limited to, implementation, evaluation, and future dissemination. Ultimately, the program strives to create healthier families in our community.

d. Wellness, Recovery and Resilience Focus: This program increases resilience and promotes discovery and wellness for parents with serious mental illness by increasing access to services. The goal is to strengthen the overall family to allow for a more stable and resilient family system with strength to sustain wellness.
e. Integrated Service Experience: This program encourages access to a full range of services provided by community resources, multiple agencies, programs and funding.

7. Continuity of Care for Individuals with Serious Mental Illness

a. Individuals with serious mental illness will receive services from the proposed project. They are a specific focus as many of the consumers will have been discharged from Organizational Provider Clinics. There is no limit on time or number of services received from the Medication Clinic, as long as medical necessity is met. At the end of the Innovations project, if this Medication Clinic concept proves successful, the fiscal support for the Medication Clinic will be achieved by exploring utilization of EPSDT Medi-Cal and federal participation funds.

8. INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement

a. Ensure cultural competence
b. Ensure meaningful stakeholder participation

9. Deciding Whether and How to Continue the Project Without INN Funds

a. Throughout the duration of the Project, steps will be taken to review the effectiveness of the approach.
b. If effective, traditional EPSDT funding streams will be considered.

10. Communication and Dissemination Plan

a. Dissemination within your county
b. Involvement of program participants and other stakeholders
c. Five (5) keywords of phrases for this Project to assist with on-line searches may include words such as medication clinic, psychiatry,

11. Timeline

a. Specify the total timeframe (duration) of the INN Project 4.5 years allowing for a 6 month final evaluation period.
b. Expected start date and end date of INN Project 7-1-18 through 12-31-22 for a total of 4.5 years
c. Key activities timeline and milestones
    i. New or changed approach
    ii. Evaluation of the INN Project
    iii. Decisionmaking, meaningful involvement about continuation of project
    iv. Communication of results and lessons learned

12. INN Project Budget and Source of Expenditures

a. Budget by fiscal year and specific budget category

b. Budget context

Position	Hourly	Annual Salary(s)	Benefits (B) (25% of Salary)	Operating (O) (30% of S+B)	Indirect (I) (15% of S+B+O)	Fully Loaded
Admin Associate	$20.00	$41,600.00	$10,400.00	$15,600.00	$10,140.00	$77,740.00
Psychiatrist	$175.00	$364,000.00	$0.00	$109,200.00	$70,980.00	$544,180.00
Program Manager	$40.00	$83,200.00	$20,800.00	$31,200.00	$20,280.00	$155,480.00
Psych Nurse	$50.00	$104,000.00	$26,000.00	$39,000.00	$25,350.00	$194,350.00
LMHP	$38.00	$79,040.00	$19,760.00	$29,640.00	$19,266.00	$147,706.00
Psychiatrist	$175.00	$364,000.00	$0.00	$109,200.00	$70,980.00	$544,180.00
		$0.00	$0.00	$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00	$0.00	$0.00
Total:		$1,035,840.00	$76,960.00	$333,840.00	$216,996.00	$1,663,636.00

Operating expenses (rent, medications, equipment, business expenses) $200,000.00

Evaluation (5% of total) $100,000.00

$1,963,636.00

Cycle 4 Innovation: Medication Clinic						
Innovation Project Budget by FISCAL YEAR (FY)						
Budget Totals	**FY 18/19**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23 (Half)**	**Total**
Personnel	$1,112,800	$1,112,800	$1,112,800	$1,112,800	$556,400	$5,007,600
Direct Costs						
Indirect Costs	$216,996	$216,996	$216,996	$216,996	$108,498	$976,482
Operating Costs	$333,840	$333,840	$333,840	$333,840	$166,920	$1,502,280
Non-Recurring Costs						
Other Expenditures	$200,000	$200,000	$200,000	$200,000	$100,000	$900,000
INNOVATION BUDGET						
Evaluation 5%	$100,000	$100,000	$100,000	$100,000	$50,000	$450,000
TOTAL	**$1,963,636**	**$1,963,636**	**$1,963,636**	**$1,963,636**	**$981,818**	**$8,836,362**

Appendix K

BHS FY 2016-17 Strategic Housing Update

County of San Diego
Health and Human Services Agency
Adult/Older Adult Behavioral Health Services

Five Year Behavioral Health
Strategic Housing Plan
FY 2014-2019

FY 2016-17 Update

Acknowledgements

The Corporation for Supportive Housing (CSH) is a Housing Technical Assistance consultant to the County of San Diego Health and Human Services Agency's Behavioral Health Services Administration. This Plan was written and produced by CSH.

About CSH

CSH transforms how communities use housing solutions to improve the lives of the most vulnerable people. We offer capital, expertise, information and innovation that allow our partners to use supportive housing to achieve stability, strength and success for the people in most need. CSH blends over 25 years of experience and dedication with a practical and entrepreneurial spirit, making us the source for housing solutions.

Table of Contents

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 Five Year Behavioral Health Strategic Housing Plan *Fiscal Year 2016-17 Update* provides a framework for the current housing needs and outlines the planning process for the development of Five Year Goals that maximize housing options for people with behavioral health issues in San Diego County.

The initial Plan was developed through a robust stakeholder process that included input from consumers, service providers, housing developers and operators, and funders of housing and services. Updates to the plan include policy and legislative updates, as well as updated feedback from consumers in the form of focus groups and surveys. 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. This 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 Five Year 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 to undertake over a five year period in order to achieve these goals, as well as a process 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.

Chapter 1: Purpose of the San Diego Strategic Housing Plan

The purpose of the Five Year Behavioral Health Strategic Housing Plan (FY 14-19) is to identify key strategies to expand and maximize housing options for people served by the County of San Diego Behavioral Health Services. This Plan explores the needs and resources in our County, identifies effective approaches to providing a range of housing options for people with limited means, and maps out how to implement strategies to expand access to housing.

The Planning Process

In FY 2013-2014, the Corporation for Supportive Housing (CSH) initiated a comprehensive effort to gather feedback from mental health and alcohol and other drug service providers, consumers of behavioral health services, affordable housing developers, and stakeholders in the homeless services community to inform the development of the Behavioral Health Services (BHS) Strategic Housing Plan. CSH has continued to convene the Behavioral Health Housing Council Work Team and to work closely with service providers to identify the current needs, refine the existing work plan, and develop solutions to housing-related challenges. CSH is collaborating with NAMI and RI International to initiate a 3-year cycle to circulate the Housing Survey for behavioral health consumers to track trends in the ways that consumers identify and maintain varied housing options. CSH continues to facilitate focus groups for Full Service Partnership (FSP) clients and residents of Mental Health Services Act (MHSA) developed housing to gather vital feedback on clients' journeys from precarious housing situations and homelessness to permanent supportive housing. CSH has continued to work with affordable housing developers and is also linked to homeless planning efforts through the Regional Continuum of Care Council and the Opening Doors (formerly 25 Cities) initiatives.

Throughout these meetings and opportunities for feedback, CSH heard the importance of identifying strategies to increase housing options for people with behavioral health issues, echoing the vision of the Behavioral Health Housing Council, an advisory body to the County:

> ***Individuals with behavioral health issues and with limited resources in San Diego County have a full range of choices for safe and affordable housing with the goal of achieving meaningful and long term recovery.***

Behavioral Health Population Overview

It is important to define the population that is the focus of the services and housing identified in this plan. Individuals who access BHS services through the Adult/Older Adult System of Care are generally low-income people with serious mental illness and/or substance use disorders. Primarily, adults and older adults accessing County behavioral health services are Medi-Cal recipients (68%, with an additional 11% covered by Medi-Cal and Medicare) and people without insurance (12%).[1] Of adult service users, some are homeless, and others may be precariously housed.

[1] BHS Databook FY 2015-2016
http://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/bhs/TRL/TRL%20Section%206/BHSDatabook_FY2015-16.pdf

FY 2015 – 2016 Data Snapshot

- 42,805 Total Unique adults and older adults accessed County Behavioral Health Services
  - 45% with a co-occurring disorder
  - 15% report that they are homeless
  - 69% are adults aged 26 – 59
  - 18% are transition age youth (TAY) aged 18 – 25
  - 13% are older adults aged 60 and above
  - 26% are in the workforce or actively seeking employment
  - 54% are not in the labor force or seeking employment
  - 20% are in residing in institutional settings or did not have employment data to report
- 11,490 Total Unique adults and older adults accessed County Alcohol and Drug Services
  - 20.8% are homeless[2]

Some BHS clients with more severe and persistent impairment are eligible for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). Among clients enrolled in FSP programs, about 70% were receiving SSI as of November 2016. For individuals living independently, the current maximum monthly SSI payment is $889.40.

In developing a Strategic Housing Plan for a behavioral health population, stakeholder feedback emphasized prioritizing planning efforts for people with serious mental illness and severe substance use disorder who have histories of homelessness, while also recognizing the importance of providing options for people who are low-income, as well as family members. At the same time, strategic planning efforts must account for the different housing needs and preferences of TAY, adults, and older adults, as well the varied income sources that could support clients who choose to live in the community.

[2] All data in the section are reported in the BHS Databook FY 2015-2016 http://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/bhs/TRL/TRL%20Section%206/BHSDatabook_FY2015-16.pdf

Chapter 2: National, State and Local Context of the Report

This Strategic Plan reflects an emerging paradigm of the importance of housing in providing behavioral healthcare both nationally and in San Diego. More and more, mainstream systems are incorporating a consideration of housing as critical to achieving health and wellness, and this broad trend is reflected in a number of important national, state and local factors that contribute to the development of this Plan.

Housing as Integral to Healthcare

The role of housing in achieving health and recovery is increasingly recognized across the country. The National Association of State Mental Health Program Directors (NASMHPD) and State Mental Health Authorities (SMHAs) have developed a housing vision and goal "to ensure that people served by the public behavioral health system have access to decent, safe and permanent affordable housing of their choice, linked with the full range of high quality services they may need to support successful tenancies".[3] This is also seen in California in the Mental Health Services Act (MHSA), which includes housing as a key component of recovery-focused services to people who are unserved or under-served by the mental health system. Changes in Medicaid-covered services and new opportunities in waiver programs reveal a growing trend to pair housing and health care resources to yield more significant outcomes for individuals with behavioral health challenges. San Diego County's decision to integrate the Department of Housing and Community Development (County HCD) within the Health and Human Services Agency (HHSA) demonstrates the local commitment to better integrate health and housing services.

National Initiatives

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and came into full effect in 2014. The Affordable Care Act (ACA) fundamentally transformed low-income individuals' and families' access to health insurance and health care, while also recognizing the importance of behavioral health treatment. In particular, the ACA requires parity or "equivalence" between medical and surgical benefits and substance use and mental health treatment options, while also focusing on quality and accountability in care. Under ACA, "essential health benefits" must be offered under health insurance plans, including such things as substance use and mental health services including behavioral health treatment. This expansion of both the number of people covered as well as the covered services greatly expanded access to substance use and mental health treatment. For example, in FY 2012 – 2013, 42% of people accessing County Behavioral Health Services were Medi-Cal recipients, with an additional 14% covered by Medi-Cal and Medicare. In FY 2015- 2016, 68% were Medi-Cal recipients with an additional 11% covered by Medi-Cal and Medicare. In addition to increasing the access to health coverage, the ACA opened the door for a variety of new funding and service delivery models that link housing and health care services.

[3]Affordable Housing: The Role of the Public Behavioral Health System, National Association of State Mental Health Program (NASMHPD) Directors Policy Brief, October 2011

At the time of the writing of this report, legislation to repeal and replace the ACA is pending Senate approval. The American Health Care Act (AHCA) would reduce federal expenditures on Medicaid and subsidies for people purchasing insurance through exchanges and would provide greater authority to states to reduce coverage. Should new policies be enacted, further analysis will be required to understand the impact on both physical and behavioral health services.

Medi-Cal 2020

Medi-Cal 2020, California's 1115 Waiver Renewal, was approved by the Centers for Medicare and Medicaid Services on December 30, 2015. Medi-Cal 2020 is a five (5) year demonstration that secures $6.2 billion in federal funds to continue various health programs and adds additional opportunities for innovative care and payment models, such as the Whole Person Care Pilot. Some of the specific programs within Medi-Cal 2020 relate specifically to hospital systems and changes in payment methodologies that will not directly affect San Diego County, but as a whole, Medi-Cal 2020 directs California counties toward more integrated health care systems with a focus on primary care and preventive services. As with the ACA, there may be programmatic and/or funding changes to programs approved under Medi-Cal 2020 and additional analysis will be provided as new policies are adopted.

Whole Person Wellness

The Whole Person Care Pilot, known as Whole Person Wellness in San Diego County, is a component of Medi-Cal 2020 that was established by the California Department of Health Care Services (DHCS) and has the goal of increasing the coordination of health, behavioral health, and social services for high-risk, high-utilizing Medi-Cal beneficiaries. This may include individuals with repeated incidents of avoidable emergency and inpatient hospital care, two (2) or more chronic conditions, and/or mental health and/or substance use disorders who are currently experiencing homelessness or are at-risk of homelessness.

The County of San Diego submitted an application in July 2016 for a Whole Person Wellness Pilot and was awarded funding in November 2016 to serve a target population of individuals who are high utilizers of health services, who are homeless or at-risk of homelessness, and have at least one of the following three conditions:

1. Serious Mental Illness
2. Substance Use Disorder
3. Chronic Physical Health Condition

Whole Person Wellness requires a one to one local match and a partnership that includes County Behavioral Health, County Public Health, other public and community-based organizations, at least one managed care organization (MCO), and a local Housing Authority. The County has successfully been approved to implement Whole Person Wellness with a service model that will create system integration teams that will provide care coordination, housing supports, and linkages to community-based services. This pilot will extend through December 2020.

Health Home Option

California passed AB361 which authorized the Health Home Option under the ACA, providing a sustainable source of funding for services in a variety of settings, including in someone's home. Eligible clients for the Health Home Option are chronically homeless as well as people who are frequent hospital users that represent the highest-risk top three to five percent of the Medi-Cal

population. The Health Home Option will fund services similar to the wrap-around services seen under MHSA, including outreach, engagement, assessment, case management, discharge planning, and other wrap-around services. DHCS is implementing the Health Homes Option in several phases state-wide and there have been delays in implementation. DHCS is planning to move forward with Health Homes in a revised timeline and is awaiting federal approval.

Drug Medi-Cal Waiver

Established through an amendment to the Bridge to Reform waiver and continued in the Medi-Cal 2020 waiver, the Drug Medi-Cal waiver would expand the number of substance use disorder services that can be reimbursed through Drug Medi-Cal, including services that could be delivered in supportive housing. DHCS requires counties to opt-in to this program, and San Diego County is currently developing a plan and will bring forward a recommendation for whether to opt-in to the Drug Medi-Cal waiver.

Regional & Local Initiatives

Project One for All

Project One for All was announced by the San Diego County Board of Supervisors in January 2016 and represents an unprecedented commitment to providing housing and mental health services to homeless San Diegans with serious mental health illness. Project One for All will provide people who are homeless and have serious mental illness access to a coordinated range of services, including housing and health care, with the goal of ending homelessness for people with serious mental illness in San Diego County. The County will be providing services to approximately 1,250 people in San Diego County who are homeless and have serious mental illness. Project One for All will increase outreach, housing, and treatment services for individuals served by the program.

Project One for All will help place people who are homeless and have serious mental illness in treatment services paired with supportive housing to fully integrate housing, mental health services, primary health care, alcohol and drug services, case management, and social services to help participants become stable and live more productive lives.

On June, 21 2016, the Project One for All Implementation Plan was approved by the County Board of Supervisors and includes funding for Outreach and Engagement services and funding for over 800 additional treatment slots to include FSPs that will serve the South and East Regions and Behavioral Health Court.[4] Furthermore, the Project One for All Implementation Plan includes current commitments of over 1,100 Housing Choice Vouchers (HCV) from County HCD, the San Diego Housing Commission (SDHC), as well as the Oceanside and Carlsbad Housing Authorities.[5] The National City and Encinitas Housing Authorities are considering updates to their Administrative Plans to commit HCVs in FY 2017-2018. In partnership with local Housing Authorities, BHS will use the Coordinated Entry System (CES) approved by the Regional Continuum of Care Council (RCCC) to integrate Project One for All with other efforts to end homelessness in the region. Project

[4] County of San Diego Board of Supervisors, Tuesday, June 21, 2016
Minute Order No. 6, Project One for All Implementation Plan
[5] Project One for All Implementation Plan, http://www.sandiegocounty.gov/content/dam/sdc/sdhcd/new-docs/Project_One_For_All_Attachment_A_Implementation_Plan.pdf

One for All will also include landlord recruitment and incentive efforts to increase the housing availability for participants.

Project One for All is a substantial infusion of resources that pair treatment and housing resources across San Diego County. BHS will maintain a performance management system to track outcomes, both short and long term, to ensure the initiative's success.

Regional Task Force on the Homeless and *Opening Doors* (25 Cities)

In 2014, San Diego joined the national 25 Cities effort supported by the Department of Veterans Affairs (VA), the U.S. Department of Housing and Urban Development (HUD), and the U.S. Interagency Council on Homelessness (USICH) to better align existing efforts around the creation of coordinated assessment and entry systems and to lay the foundation for ending homelessness, specifically homelessness among Veterans. Through the 25 Cities efforts, significant progress was made in developing a region-wide Coordinated Entry System (CES) (formerly known as the Coordinated Assessment and Housing Placement (CAHP) system) per HUD requirements. At the same time, the Regional Continuum of Care Council (RCCC) was engaged in strategic planning efforts around coordinated entry implementation, improved coordination around Homeless Management Information Systems (HMIS), and updated scoring, evaluation, and monitoring of RCCC-funded programs. As the 25 Cities effort and the RCCC were pursuing parallel objectives to end homelessness in the region, the decision was made to merge the 25 Cities effort into the existing RCCC governance structure and to re-name 25 Cities as Opening Doors. The Opening Doors Committee of the RCCC would continue the strategic efforts of 25 Cities by focusing on veteran and chronic homelessness with a priority of developing a By Name List (BNL) of homeless veterans. The merging of 25 Cities and the RCCC represents efforts to leverage resources and increase partnerships with the goal of ending homelessness. In addition, in January 2017, the Regional Continuum of Care Council (RCCC) merged with the Regional Task Force on the Homeless (RTFH). The Regional Task Force on the Homeless is now the coordinating body with the key goal of ending homelessness throughout the San Diego region.

On a related note, the HUD Continuum of Care Formula is currently under evaluation, and HUD is currently reviewing public comments. This review was sparked by Rep. Scott Peters of San Diego as the current funding formula does not adequately match funding with community need and rates of homelessness. While potential funding changes, if implemented, would not be in place for several years, this change could represent an increase of funding to the RCCC for housing and services in the future.

Veterans' Homelessness Initiatives

Regional strategies are currently in place to address to address homelessness among veterans through permanent supportive housing. The HUD-Veterans Affairs Supportive Housing (HUD-VASH) program pairs Housing Choice Vouchers (HCV) from County HCD or SDHC with case management and clinical services provided by the VA.

In 2016, a new strategy around landlord incentives was launched in both the County Housing and Community Development Department (HCD) and the City of San Diego. This program offers financial incentives to participating landlords, as well as assistance to tenants for security and utility deposits, with the goal of helping homeless veterans find housing in the private market. These efforts offer a dedicated liaison to participating landlords to address concerns and provide individualized customer service. According to the FY 2015-16 Special Population Report, the BHS

Adult System of Care provides treatment services for 1,482 veterans, so there are opportunities to support current BHS clients who are veterans. Landlord incentive programs are a promising strategy that, if successful in serving the veteran population, could be expanded to serve other populations including individuals with serious mental illness and substance use disorders.

Physical/Behavioral Health Integration

BHS has worked to advance the integration of physical and behavioral health services through several initiatives and strategies. Through the Healthy San Diego Behavioral Health Workgroup, BHS collaborates closely Medi-Cal Managed Care Organizations (MCOs) to build referral networks and ensure continuity of care for clients who move between different levels of care. BHS also partners closely with community clinics across the region to transition clients from specialty mental health that serves individuals with serious mental illness to primary care where persons with low to moderate mental illness can access treatment.

HHSA has also extended this integrated model across the agency by creating an Office of Integrative Services to strengthen the connections between housing, physical health, and behavioral health services.

Housing Development Resources

Affordable housing resources have been greatly impacted by several factors over recent years, including the dissolution of redevelopment agencies in California and the near exhaustion of the affordable housing bond financing that had previously been available under Proposition 46 and Proposition 1C.

While budget sequestration reduced funding for rental subsidies from SDHC and County HCD in 2013, funding has stabilized and SDHC has been able to make additional sponsor-based and project-based commitments to Project One for All, including 31 project-based subsidies for MHSA units at Atmosphere, a 205 unit, affordable housing development in downtown San Diego. County HCD has also allocated tenant based vouchers for BHS clients in East County, and Project One for All represents an influx of new partnership subsidies for BHS from several Housing Authorities in the region.

There are several new sources of housing funds that could support the creation of affordable and supportive housing for people with behavioral health issues, including:

Special Needs Housing Program

The Special Needs Housing Program (SNHP) was created to replace the expiring MHSA Housing Program and allows San Diego County to continue the development of supportive housing for MHSA-eligible persons and to more fully utilize MHSA funds for housing purposes. The California Housing Finance Agency (CalHFA) operates the SNHP on behalf of jurisdictions throughout California, thus allowing local governments to use MHSA funds to provide financing for the development of permanent supportive housing that includes units dedicated for individuals with serious mental illness, and their families, who are homeless or at risk of homelessness. Like the MHSA Housing Program, SNHP can fund the development of new housing opportunities with funding for capital development and operating subsidies. SNHP funding can also supplement expiring capitalized operating subsidy reserve (COSR) accounts to ensure a longer term of affordability for the residents in current MHSA developments. In 2015, the County Board of Supervisors allocated $10 million in MHSA funding to SNHP.

No Place Like Home

On July 1, 2016 Governor Jerry Brown approved the creation of the No Place Like Home (NPLH) program to help address homelessness among persons with serious mental illness. The initiative will be administered by the California Department of Housing and Community Development (State HCD) and provides funding for a grant program for the construction and rehabilitation of supportive housing for individuals with mental illness who are homeless, chronically homeless or at risk of chronic homelessness. NPLH is a $2 billion bond leveraged by a portion of future Proposition 63 mental health revenues. In addition to providing funding for capital projects, some of the bond proceeds can be used for tenant-based rental assistance and direct technical assistance to localities.

The program will include $1.8 billion in funding for a statewide supportive housing development program, as well as $200 million to be distributed to counties for construction, rehabilitation or preservation and capitalized operating costs of permanent supportive housing for persons who are eligible for MHSA services. Additional funding will support technical assistance from State HCD who will fund awards in at least four annual rounds. Counties may participate in a competitive application process, but counties with a large homeless population may apply for a population-based award. Should San Diego County choose the second option; it would have access to an estimated $135 million in total capital development and operating subsidy funding. Many of the details surrounding the rollout of NPLH are still in development, and the first NOFA from State HCD is not expected until summer 2018 at the very earliest. NPLH is a new infusion of development funding for permanent supportive housing for persons with serious mental illness and demonstrates a new commitment at the state level to address housing challenges across the state.

National Housing Trust Fund

The National Housing Trust Fund (NHTF) is a dedicated fund, implemented in 2016, intended to increase housing resources for people with the lowest incomes. The NHTF will provide communities with funds to build, preserve, and rehabilitate rental homes that are affordable for extremely and very low income households. In this first year, HUD announced nearly $174 million nationally and $10 million for California. Like No Place Like Home, the NHTF will be administered by State HCD through an annual process and an priority will be given to special needs populations. NHTF can be paired with Community Development Block Grant (CDBG) and HOME funds as set forth in the State HCD Annual and Consolidated Plans.

Civic San Diego Affordable Housing Master Plan

The Plan, which was adopted in May 2013 and updated in October 2015, strives to maximize the number of new affordable housing units that can be produced with the remaining redevelopment housing assets by leveraging the City of San Diego's funds with other funding sources. The plan also prioritizes the production of homeless housing and contemplates the requirement that developers set-aside permanent supportive housing in affordable housing developments that receive funding. Civic San Diego funding supported the development of Alpha Square, a 201-unit affordable housing development in downtown San Diego that also had 76 project-based subsidies. Civic San Diego funding has also supported the Atmosphere and Churchill MHSA developments. The updated Plan also outlines options to increase affordable housing development in Southeast San Diego.

Expanding Role of Data

In the increasingly integrated worlds of health and housing, data is a precious resource. Data can help to leverage funding across multiple streams for individuals who are accessing social services, housing supports, and physical and behavioral health services across different systems. Data sharing has been instrumental in supporting frequent utilizer initiatives like Project 25 as providers team up to serve their most challenging consumers. At the same time, the Health Insurance Portability and Accountability Act (HIPAA) and other policies that protect privacy and confidentiality must be upheld in the implementation of more streamlined data sharing efforts.

Regionally, numerous data management and data sharing efforts are coalescing that could better integrate data into the decision-making processes around service delivery, resource allocation, and policy making. The County is actively working with partners focused on homelessness (such as the Regional Task Force on the Homeless) and health (such as the Managed Care Organizations) to match data across systems and identify the most frequent users of high cost systems of care, who have complex and chronic conditions and experiences of homelessness.

Coordinated Entry System (formerly Coordinated Assessment and Housing Placement)

The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 required that communities receiving HUD funding for homeless services develop a coordinated entry system for shelter, rapid rehousing, prevention, transitional housing and permanent supportive housing.

Successful coordinated access systems can help communities move toward their goal of ending homelessness by matching people with the housing and support they need and connecting them to those resources quickly. Coordinated access can:

- Help unclog the system by moving people more quickly through the referral process
- Reduce duplication of efforts and help serve clients better
- Assist communities with ending chronic homelessness by sparking conversations about targeting the most expensive resources to those that have been homeless the longest.

Through the 25 Cities initiative, significant progress was made in developing a regional coordinated access system. In 2014, a common assessment tool (CAT) was identified, the Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT). In early 2016, the Coordinated Entry System (CES) was integrated into the regional Homeless Management and Information System (HMIS), Service Point. In August 2016, CES launched in East County and the South Bay and service providers in these areas will be able to assess clients and allocate housing resources using CES.

BHS has been involved in the planning around CES implementation by developing supplemental questions to the VI-SPDAT that provide information related to mental health acuity and result in more appropriate referrals to behavioral health providers. This Common Assessment Tool (CAT) is providing early self-reported data that can potentially be used to identify individuals in the CES system and refer homeless individuals to supportive housing that is matched with MHSA supports.

BHS is already participating in CES through the lease-up of MHSA Housing developments like the Churchill and Atmosphere. CES is being implemented at the various MHSA developments where

the SDHC has provided project-based and sponsor-based subsidies (Churchill, Atmosphere, Celadon, Parker Kier, and Mason). BHS is also testing CES through a partnership with County HCD to provide Housing Choice Vouchers to homeless individuals receiving mental health outpatient treatment. While homeless service providers who receive funding from HUD and the VA are required to utilize CES, successful coordinated access systems include the participation of all housing and service providers in the community.

Community Information Exchange

The Community Information Exchange (CIE) is operated by 2-1-1 San Diego with the goal of facilitating care coordination for individuals accessing social and health services in the community. The CIE allows for data sharing across providers, so staff has access to valuable data around health, housing status, and other client data to inform service planning decisions.

CIE is in its nascent stage, and the network of participating agencies is still growing, but it already includes several large hospitals, senior services, homeless services providers, community clinics, and emergency medical services (EMS). Participating providers can adapt their level of integration into CIE and this can range from submitting reports to 2-1-1 San Diego for upload into the system to fully integrating CIE's dashboards into an organization's native case management or Electronic Health Record (EHR) system. CIE is also set up to work collaboratively with the County's Connect Well SD initiative (formerly the Knowledge Integration Program - KIP), the Homeless Management Information System (HMIS) operated by the Regional Task Force on the Homeless, and San Diego Health Connect, the regional Health Information Exchange. While these connections are in place, legal and programmatic requirements to protect consumer privacy and confidentiality are still being explored. The CIE only shares data for individuals who have an active consent on file, and this consent may be changed or revoked at any time. CIE offers an opportunity to better serve clients by providing a more complete picture of client needs, but will require significant cooperation between providers across systems to provide the kind of robust data that can truly transform service delivery.

San Diego Health Connect

San Diego Health Connect (formerly Beacon HIE) is the regional health information exchange (HIE) that links health systems, hospitals, physicians, and health plans. San Diego Health Connect includes several components including a Medical Records Exchange where providers can review patient medications, allergies, immunizations and recent test results, as well as progress notes, discharge summaries and operative reports. The system can also generate alerts for transitions in care such as a visit to the emergency room or an admission or discharge from a participating hospital. Aggregate data from the system is used for public health reporting.

Like the CIE, the success of San Diego Heath Connect is dependent on the participation of providers across health system and the quality of the data in the system. While numerous hospitals and community clinics are linked to San Diego Health Connect, there is limited participation from specialty mental health and substance use services.

Connect Well SD

The County is also pursuing a data sharing platform, Connect Well SD, that will connect information systems from departments within HHSA, including BHS, County HCD, Aging and Independence Services (AIS), Child Welfare Services (CWS), Public Health Services (PHS), Self Sufficiency Programs, as well as data from the Probation Department. Connect Well SD will use integrated data

to support service delivery improvements that are person-centered, strengths-based, and trauma-informed.

The County is implementing Connect Well SD in three phases with BHS data from Cerner incorporated into Connect Well SD in phase two in late 2016. The three phases also correspond to increased functionality in data management with phase three, planned for late 2017, bringing system notifications and sharing across all County departments. The County's legal staff is engaged in reviewing all privacy laws and regulations, and several work teams have convened to monitor the roll-out process. While Connect Well SD represents a huge step forward in data sharing, there is limited information about consumer housing status and needs within these County systems. BHS's Cerner system serves as an electronic health record (EHR) for BHS, but does not include detail on housing status.

To optimize the potential of data-sharing, the County will need to link to the CIE and San Diego Health Connect for the most complete picture of consumer needs. A mechanism to link to the regional HMIS will provide additional perspective on how clients are accessing homeless services in the community.

Data Driven Justice Initiative

In 2016, the White House launched the Data Driven Justice Initiative (DDJI) to divert low-level offenders with mental illness and histories of homelessness out of the criminal justice system. The DDJI, now supported by the National Association of Counties, operates as a coalition of city, county, and state governments who have committed to using data-driven strategies to reduce jail populations and connect persons to appropriate services in the community. San Diego County is participating in this initiative and staff from the County's Health and Human Services Agency (HHSA) and Public Safety Group (PSG) are working to develop mechanisms to clearly identify the number of individuals who cycle between homelessness and the justice system to better target interventions and reduce recidivism. Through the initiative, HUD selected six communities to work with HUD Technical Assistance providers to develop a data sharing system that connects criminal justice data with the regional Homeless Management Information System (HMIS) with the goal of identifying housing resources and services to comprehensively address people's needs.

Recently, the California Department of Justice has clarified regulations regarding the sharing of criminal justice data. County stakeholders are advocating for DOJ approval to allow for data sharing between regional partners to continue the DDJI as well to support other initiatives such as Project One for All and Whole Person Wellness that have outcomes related to reductions in jail days.

Chapter 3: Identified Health, Income, and Housing Needs

San Diego County's most recent Community Health Assessment from 2014 revealed that almost 169,000 adults likely had serious psychological distress during past year.[6] Additionally, a SAMHSA report from 2014 estimates that 1 in 10 people aged 12 and older used an illicit drug within the past thirty days.[7] Though the exact number is not known, as there is some overlap between the group due to some individuals having a co-occurring disorder, it is clear that a significant number of people in the community are facing some sort of behavioral health challenge. Many of these individuals have physical health challenges as well. However, only a subset of these individuals actually has a housing need. Housing challenges and needs and available data on the numbers of people in each need area are summarized below.

Health

In 2012, chronic disease was responsible for 54% of all deaths in San Diego County.[8] Physical health challenges can create additional barriers to people with behavioral health needs in finding and maintaining housing that meets their needs. People with chronic disease may experience frequent hospitalizations and/or institutionalization to manage their illness, and this could compromise their housing stability.

Consistent with national trends, the population of seniors in San Diego County is growing with over 368,222 individuals aged 65 and over.9 In FY 2014-2015, BHS served almost 5,500 adults over age 60, up from 3,338 in FY 2006- 2007. At the same time, research is showing an increase in homelessness and poverty among older adults. Nationally and here in San Diego the homeless are aging, with nearly half of the homeless in San Diego over the age of 50 (3,829 homeless are aged 55 in the County of San Diego, and 1, 344 were unsheltered homeless). These changes in population health around the aging population and chronic disease only serve to emphasize the need for integrated health care and housing services.

Income

Income is critical to housing stability for the behavioral health population. An adequate income would cover the cost of secure, safe, and affordable housing. However, housing in the San Diego region is among the most expensive in the nation. Families and individuals from all walks of life are affected by San Diego's high housing costs. An individual earning minimum wage in San Diego County would have to work 115 hours per week to afford a two-bedroom apartment at fair market rent.[10] On a positive note, San Diego County's unemployment rate was 5.1% as of June 2016 and has

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[6] County of San Diego, Health and Human Services Agency. Live Well San Diego Community Health Assessment. June 2014.
[7] Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf
[8] County of San Diego, Health and Human Services Agency. Live Well San Diego Community Health Improvement Plan. June 2014.
[9] County of San Diego, Health and Human Services Agency. Live Well San Diego Community Health Assessment. June 2014.
[10] Out of Reach 2016. National Low Income Housing Coalition. http://nlihc.org/oor

been decreasing consistently from a rate of over 10% in 2010.[11] While employment has been increasing across numerous sectors, the most significant gains have been in Leisure and Hospitality and Education and Health Services. The majority of individuals served by the County's Behavioral Health programs have employment related outcomes identified in their treatment and recovery plan and actively participate in a range of employment programs and supports designed to assist them in achieving long-term economic stability. Over the past several years, BHS has prioritized employment, not only as a source of income, but also as a tool in the recovery process. In 2014, BHS developed a Five-Year Strategic Employment Plan with a focus on evidence-based practices around supported employment and social enterprise. In FY 2015-2016, 11% of adults and older adult receiving BHS services were employed with an additional 15% actively seeking employment.[12] This represents an increase of 1% from the prior year.

Supplemental Security Income (SSI) or other benefits are critical sources of income for BHS consumers. Census estimates indicate that over 51,000 households in San Diego County receive SSI.[13] There are a number of organizations and initiatives in San Diego, including Legal Aid Society of San Diego, Homeless Outreach Programs for Entitlement (HOPE) San Diego (the region's local SOAR initiative[14]), and Benefit Specialists embedded in various County-funded programs, that assist individuals with obtaining SSI benefits. It is important to note that individuals who submit claims for SSI based on a functional disability will be denied benefits if it is determined that substance use is a primary contributing factor to that person's functional impairment. This underscores the critical importance of employment related supports and programs specifically designed for people with substance use disorders and functional impairment, as many of these individuals may be deemed ineligible for disability benefit income because of their substance use.

Housing Status

Literally Homeless

The 2016 San Diego Point in Time Homeless Count took place in San Diego County on January 29, 2016 and identified 8,692 persons who were homeless on that single night (including both people in shelter and transitional housing as well as the unsheltered homeless). The Point in Time Count also provides an estimate of the number of unsheltered homeless people with behavioral health issues on that night based on in person interviews that included in the count. On that night, it is estimated that there were 674 unsheltered homeless people with mental illness and 392 unsheltered homeless people with alcohol or drug abuse[15]

This data represents a downward trend in unsheltered homeless individuals reporting serious mental illness and/or substance use disorders. The 2013 Point in Time Count reflected 1,784 unsheltered homeless with serious mental illness and 1,555 with substance use disorders. However, this data does not include the sheltered population of 3,752.

[11] Bureau of Labor Statistics. http://www.bls.gov/regions/west/ca_sandiego_msa.htm
[12] BHS Databook FY 2015-2016.
[13] Selected Economic Characteristics, 2010-2014 American Community Survey 5-Year Estimates, US Census Bureau
[14] https://soarworks.prainc.com/
[15] Regional Task Force on the Homeless, www.rtfhsd.org

For people who are homeless and have mental illness or substance use disorders, housing is a critical and basic need. Without some kind of housing intervention, they will continue to live on the streets, in vehicles, tents, or cycle in and out of shelter. For this group, the presenting need is a safe and affordable place to live, coupled with the supports needed to address their behavioral health issues so as to help find and sustain housing of their choosing.

Precariously Housed

While not homeless, a larger group of people with mental illnesses and/or a substance use disorder are precariously housed.[16] In addition to having very insecure living situations, they also face a range of other challenges (e.g. low educational attainment, histories of unemployment, poor heath histories, domestic violence histories, involvement with the criminal justice and/or child welfare systems, etc.). There is no single data source that allows us to know how many people with behavioral health issues are precariously housed; however, some sources have attempted to develop an estimate:

- The FY 15-16 BHS Databook shows a housing status of Other or Unknown for about 7,000 BHS clients, in addition to the over 5,500 who are currently homeless. While there are a variety of factors that could result in a housing status of Other or Unknown, it is likely that some portion of that population does not have regular or secure housing. Furthermore, homeless data collected by BHS is self-reported. Persons who self-report as homeless may not meet MHSA and/or HUD homeless criteria, but they may be in a housing situation that is not safe or secure.
- People with incomes at or below the federal poverty level ($24,300) annually for a family of four) are generally assumed to be precariously housed and have a high need for affordable and safe housing simply by virtue of their extremely low incomes and the difficulty of finding housing they can afford. Census data indicates that 14.7% of the population of San Diego County lives at or below the Federal Poverty Level.[17] This percentage is far higher among people with behavioral health issues. Anyone living solely on SSI income would fall below the Poverty Line.

It is important to note that there are a variety of interventions that can help stabilize housing for people with very low incomes who also have behavioral health issues (e.g. short and long term rental subsidy programs; dedicated affordable housing units; supportive housing; etc.). Not all those who are precariously housed need the highest cost interventions (i.e. permanent supportive housing).

Rent Burdened

While not all people with behavioral health issues are precariously housed, the vast majority do experience difficulty in affording housing.[18] In a 2016 survey of San Diego County behavioral health clients, almost 77% of respondents indicated that inability to afford rent was a barrier to securing housing. This is consistent with data collected in the 2013 BHS Housing Survey.

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[16] Precariously Housed is defined by the federal department of Housing and Urban Development (HUD) as people on the brink of homelessness. They may be doubled up with friends and relatives or paying extremely high proportions of their resources for rent. They are often characterized as being at imminent risk of becoming homeless.

[17] Selected Economic Characteristics, 2010-2014 American Community Survey 5-Year Estimates, US Census Bureau

[18] HUD defines "rent burden" as paying more than 30% of household income for rent. However, we should note that there is not necessarily a strong correlation between being "rent burdened" and being precariously housed, since the vast majority of low income people do pay more than 30% of their income for rent and many or most of those people do not experience persistent housing instability.

Additional data in the region confirms the high cost of housing in San Diego:

- *Priced Out in 2014* is a biennial national rental housing study conducted by TAC Inc. documenting the severity of housing affordability problems experienced by the lowest-income people with disabilities. Priced Out calculates the difference between what an individual receiving SSI can reasonably afford to pay for housing costs and the average cost of modest housing units. The most recent edition of *Priced Out* once again demonstrates that non-elderly adults with disabilities who rely on SSI are the group most affected by the extreme shortage of decent and affordable rental housing across the nation.[19]
- In the San Diego Metropolitan Statistical Area (MSA) area, the average 2016 monthly SSI payment is $889.40, or 17% of the region's median income. In order to afford a one bedroom apartment, an SSI recipient would have to spend 131% of his or her SSI monthly income on rent or 119% to rent an efficiency or studio apartment.[20]
- Very few of the County's behavioral health consumers are currently able to access the Housing Choice Voucher Program (Section 8), with only 6% of survey respondents reporting they are currently receiving Section 8 and only 20% report that they know they are currently on the waiting list. There are approximately 46,000 households in the City of San Diego and the Section 8 waiting list, and the average wait to obtain a housing voucher is 8 to 10 years.

Housing Trends

The cost of housing in San Diego County is extremely high. A metric that captures the cost of housing is Fair Market Rent, established by the US Department of Housing and Urban Development which has gone up by approximately 20% over the last ten years. San Diego County's Fair Market Rent (FMR) declined for several years after a peak in 2011, but has now rebounded to a new high. Most very low income households are unable to afford the fair market rent of $1,040/ month for a studio or $1,153 for a one-bedroom apartment. As discussed above, San Diegans with a disability would have to pay 131% of their monthly SSI to rent a modest one-bedroom apartment and 119% to rent a studio.

Fair Market Rent (FMR) Ten-Year History for San Diego County, CA[21]

Year	Efficiency	1 Bedroom	2 Bedrooms	3 Bedrooms	4 Bedrooms
2016	$1,040	$1,153	$1,499	$2,167	$2,329
2015	$964	$1,060	$1,390	$2,021	$2,462
2014	$939	$1,032	$1,354	$1,969	$2,398
2013	$959	$1,054	$1,382	$2,009	$2,448
2012	$984	$1,126	$1,378	$1,960	$2,421
2011	$1,004	$1,149	$1,406	$1,999	$2,470
2010	$945	$1,082	$1,324	$1,883	$2,326
2009	$1,024	$1,168	$1,418	$2,067	$2,493
2008	$978	$1,117	$1,355	$1,976	$2,382
2007	$870	$993	$1,205	$1,757	$2,118

[19] Priced Out in 2014, http://www.tacinc.org/media/52012/Priced%20Out%20in%202014.pdf
[20] Selected Economic Characteristics, 2010-2014 American Community Survey 5-Year Estimates, US Census Bureau
[21] HUD Fair Market Rent, https://www.huduser.gov/portal/datasets/fmr.html

Apartment Vacancies

Apartment vacancy rates in San Diego are also extremely low, with the vacancy rate below 3% across the County. In the spring of 2013, the overall apartment vacancy in San Diego County was 4.5%. Vacancy in the City of San Diego was 4.8% and in the rest of the County, 4.4%. The decrease in the vacancy rate increases the competition for rental homes and drives up rental rates making it even more challenging to find safe, affordable housing. Furthermore, individuals who are able to secure a housing subsidy are challenged to find landlords who will accept vouchers due to high demand for rental units.

2016 Vacancy Rates By Region[22]

Region	Vacancy Rate
North County	2.4%
City of San Diego	2.8%
East County	2.4%
South Bay	2.2%
Countywide	**2.6%**

Stably Housed But Needing More Independent Housing Option

Another area of housing need involves behavioral health consumers who are residing in Board and Care facilities, Sober Livings, Independent Living Homes and other kinds of residential programs, who are capable of living more independently and who express a desire to "move on" to their own apartment or home. In the client survey described above, 56% of those living in Board and Care indicated they wanted their own house or apartment. This was also true of those living in Sober Livings (52%) and Independent Living Homes (43%). Additionally, 36% of consumers living with family expressed an interest in moving to their own independent apartment.

Housed But Needing Environment More Conducive to Recovery

A final area of housing need is those people who are housed but identify their current housing environment as not being conducive to recovery because of proximity to other people who are using drugs or alcohol. No data is currently available that allows us to project how many people with a substance use disorder in San Diego County (some of whom may also have co-occurring mental health issues) are living in such environments and would choose other living arrangements if available.

For this group, housing is a "need" in the sense that having a safe and stable place to live may be a key support for recovery. It is widely accepted within the substance use treatment field that people with addictions to alcohol and other drugs need both treatment, plus a range of community-based resources to support recovery, including a safe environment in which to live. For many consumers, living in neighborhoods or buildings where there is a high degree of open drug sales and use of drugs makes it very difficult to abstain from or reduce their substance use. It is also believed that safe living situations also provide an essential environment in which healing and recovery can take place. *For more information regarding housing planning for people with substance use disorder, please see the San Diego Alcohol and Drug Services Housing and Services Report 2013: http://sandiego.camhsa.org/housing.aspx*

[22] Market Update, First Quarter 2016. Apartment Realty Group

However, for many of the people who have a substance use disorder, housing is not necessary as a way to prevent homelessness. People may live in housing that is not conducive to good health, but there is no imminent risk that they would become homeless. Research suggests that many people who appear to be "at risk" of homelessness are actually quite unlikely to end up on the streets or in shelters if they do not receive housing assistance and instead will continue finding temporary housing situations.[23]

HUD has also issued guidance on the role of Recovery Housing as a valuable component within an array of housing choices for persons with substance use disorders. Recovery Housing programs can be operated as transitional housing or permanent supportive housing that emphasizes abstinence, while still maintaining the principals of *Housing First.*[24] Recovery Housing should be low-barrier and offer peer support to residents who choose to live in an environment that will better support their recovery. Agencies like Central City Concern in Portland, OR have introduced Recovery Housing as part of a continuum of housing options that offer appropriate options for clients at various stages in the recovery process.

San Diego Behavioral Health Housing Survey

From June to August 2016, the behavioral health community distributed surveys to San Diego Behavioral Health Services clients in a wide range of settings, including through community partners such as NAMI and RI International, as well as the clubhouses, hospitals, board and cares, residential treatment facilities, sober living, independent living homes, etc. In addition to the survey, respondents received a resource handout that described a wide range of housing resources in San Diego, which is included in Appendix C. This survey was only revised slightly from the 2013 housing survey and, in many cases, the responses are very consistent with housing affordability remaining the most significant barrier to securing housing.

Over 1,600 unique surveys were completed, providing a rich set of information regarding behavioral health clients' experiences of housing. Respondents overall wanted higher quality housing than their current housing situation, but were realistic about financial limitations. There was considerable interest expressed in:

- living in a "place of my own"
- affordability
- greater privacy
- to be reunited with children
- to live with a significant other
- ability to have pets
- home ownership

The greatest obstacles expressed revolved around income and affordability. Housing is not affordable for the respondents and they identified the following barriers:

- 53% of respondents reported lack of income to afford current rent
- 41% of respondents reported lack of income to cover 1st month and security deposit
- 37% of respondents reported not being able to afford to live in a desirable neighborhood

[23] http://www.endhomelessness.org/library/entry/prevention-targeting-101
[24] Recovery Housing Policy Brief. https://www.hudexchange.info/resource/4852/recovery-housing-policy-brief/

- 32% of respondents reported lack of income to cover security deposit
- 32% of respondents reported not being able to afford to live in a neighborhood where they feel safe
- 29% of respondents reported insufficient income to afford rent and food
- 28% of respondents reported problems with credit check

Other barriers include stigma with having a mental illness, racial discrimination, pet policies, lack of transportation, LGBT discrimination, cost of prescriptions, poor rental history, and criminal background checks. Many survey respondents noted poor credit histories and could benefit from assistance in applying for housing.

Finally, respondents expressed a need to better understand Section 8 housing subsidy, particularly how to apply for Section 8 and keep current on the list:

- 6% of respondents reported currently receiving Section 8
- 20% of respondents reported being on the Section 8 waitlist
- 24% of respondents reported not knowing whether they were on the waitlist or not
- 17% of respondents reported having difficulty keeping their information current on the Section 8 waitlist with another 42% reporting that they don't know if their information is current

The 2016 data related to Section 8 demonstrated a reduction in the percentage of respondents who had Section 8 and who report being on the Section 8 waiting list compared to data from 2013. At the same time, fewer respondents indicated they have difficulty keeping their information current and only about 15% stated that lack of internet access was a barrier to keeping their information current while this represented a much more significant barrier in the 2013 survey results.

Chapter 4: Housing and Services Resources

There are a range of housing options that are dedicated to or available to people with behavioral health issues in San Diego. Appendix E includes an inventory of housing that is available in San Diego for people with mental illness or people in recovery from substance use disorder. Note that some of this housing is dedicated to people with behavioral health issues, however much of it is available to, but not necessarily dedicated to, a behavioral health population. The range of housing options is described below.

Behavioral Health Housing Options

- *Emergency Shelter* – Beds are dedicated to homeless individuals regardless of mental illness condition. There are some specific emergency shelter beds that are designated for persons with mental illness. Residents may stay up to 90 days. Example: Interfaith Community Services' Tikkun Home.
- *Licensed Board & Care (B&C)* – Board and Care facilities, licensed by the State of California Community Care and Licensing Division, are permitted to dispense medications. Most Board and Cares in San Diego County provide care for less than ten residents at a time, although a small number have space for more than 40 residents. The purpose of the Board and Care facilities is to provide continued outpatient stability. In most facilities, residents share rooms. Example: Volunteers of America's Troy Center.
    - *Augmented Services Program* – B & C that provided additional support services for clients enrolled in the program via case management services.
- *Independent Living Home* - The term Independent Living Home is used to describe a wide array of housing for many different types of residents. Independent Living Homes (ILHs) who are members of the *Independent Living Association* are privately-owned homes or complexes that provide housing for adults with mental illness and other disabling health conditions. They serve residents that do not need medication oversight, are able to function without supervision, and live independently. ILHs may serve as transitional housing for residents who are receiving financial support to live in the home, but may also provide permanent housing for residents who wish to live in a shared housing environment.
- *Sober Living* – Alcohol-free and drug-free living facilities for individuals in recovery from alcohol or drug addiction. There are a limited number of these facilities in the County that specifically target individuals with mental illness. Example: Mental Health Systems, Inc.'s Sisters Sober Living.
- *Transition in Place/Rapid Rehousing* - provides financial assistance and services to prevent individuals and families from becoming homeless. Helps those who are homeless to be quickly re-housed and stabilized, such as short or medium-term rental assistance, mediation, credit counseling, security or utility deposits, utility payments, moving cost assistance, and case management. Example: San Diego Housing Commission Rapid Re-Housing Program.
- *Transitional Housing* – Beds are dedicated to homeless individuals with mental illness. Tenants may stay for a time-limited period, ranging from 3 months up to 2 years. Tenants must participate in programs and services offered in Transitional Housing. Example: Episcopal Community Services' Uptown Safe Haven.
- *Permanent Supportive Housing* – Units are dedicated to individuals with mental illness. Tenants hold leases with no limit to length of stay. Services are primarily voluntary and not a condition for remaining in the housing. Not a treatment environment. Example: The

Association for Community Housing Solutions' (TACHS) Reverend Glenn Alison Apartments.

- *Affordable Housing* - Any housing in which the financing and/or operations are subsidized to make the units affordable to people who are low income. On-site services include coordination (information and referral, tenant problem solving), adult education classes and community building activities. Example: Wakeland, Community Housing Works, Chelsea Investment Corp.

Special Programs in San Diego

In addition, San Diego has established a number of special programs that offer additional housing options for people with behavioral health issues, including:

- *HOME-Family Reunification Tenant-Based Rental Assistance Program*: Since 2004, the County of San Diego has funded a tenant-based rental assistance program for approximately 40 families participating in the Dependency Court's Substance Abuse Recovery Management System (SARMS) program. It is a collaborative effort among the County Health and Human Services Agency Behavioral Health Services and Child Welfare Services departments, the Housing Authority of the County of San Diego, and the County Department of Housing and Community Development.
- *Serial Inebriate Program (SIP):* In 2000, the nationally recognized "best practice" Serial Inebriate Program began an innovative effort to reduce the number of chronic homeless alcoholics cycling in and out of detox centers, jails, and local emergency rooms. The City/County-funded program offers treatment in lieu of custody time for public intoxication. Services and housing are provided to program participants through the program operator, Mental Health Systems, Inc., over a six-month period of time.
- *Vulnerability Index*: The Ending Homelessness in Downtown San Diego Campaign leads an effort to identify, house and provide services to the most vulnerable homeless individuals sleeping on the streets of downtown San Diego, including those with mental illness and substance use disorders. The San Diego Housing Commission and the County of San Diego's Health and Human Services Agency combine resources together to provide homeless households with permanent supportive housing and wraparound services.
- *Project 25*: In 2011, the United Way of San Diego "Home Again" campaign, in partnership with the County of San Diego Behavioral Health Services, the San Diego Housing Commission, Telecare, and St. Vincent de Paul Village, began San Diego's first "Frequent User" initiative, which identified at least 25 of San Diego's chronically homeless individuals who are among the most "Frequent Users" of public resources and provided them with long-term housing and supportive services. Since the United Way funding ended, this project is now funded by SAMHSA and Managed Care Organizations.
- *AB109*: Starting on October 1, 2011, Criminal Justice Alignment began in California, meaning that non-violent, non-serious, and non-sexual criminals can now serve sentences locally. To respond to the needs of homeless AB109 offenders, the County provides up to 12 months of transitional housing support to qualified realigned offenders as they work toward self-sustainability. The Housing Program provides a safe, sanitary, and stable living environment in accordance with the assessed needs of participants, thereby increasing their ability to achieve their conditions of probation, gain reliable income, and successfully re-integrate in the community.
- *Home Finder*: Launched in July 2016, the Home Finder Program serves adults who are connected to BHS through outpatient clinics and are experiencing housing instability. The

contractor, Alpha Project, will provide housing search resources, a centralized hub for roommate matching, and flex funds to support housing retention.

- *100 Homeless Initiative*: In December 2015, the County of San Diego and the San Diego Housing Commission released a joint Request for Proposals (RFP) that will match assertive community treatment and substance use services with housing subsidies to serve 100 homeless individuals. The client population will include 45 MHSA-eligible individuals with serious mental illness and 55 individuals with substance use disorders. This program represents the first time that services and housing resources have been paired to serve individuals with a primary diagnosis of substance use disorder. The County awarded the contract for the 100 Homeless Initiative in late 2016 and services began in 2017.
- *Moving On Program*: In partnership with the San Diego Housing Commission, BHS will participate in a pilot program to offer Housing Choice Vouchers to FSP clients who are clinically stable and have demonstrated an interest in "moving on" from permanent supporting housing. Moving On participants will receive transitional assistance to help them identify housing and community resources to live independently in the community at a lower level of care.

Housing Development Resources

The need for additional affordable and supportive housing in the San Diego region is clear. In seeking to leverage local, state and federal funds to create new affordable and supportive housing opportunities, it is important to maximize the use of these available resources:

- 4% and 9% Low Income Housing Tax Credits (LIHTC)
- Conventional Financing / Loans
- Federal Home Loan Bank Affordable Housing Program (AHP)
- Local Continuum of Care resources (Homeless Emergency Assistance and Rapid Transition to Housing - *HEARTH*)
- Locally controlled Housing Funds:
    - Civic San Diego and other redevelopment successor agencies
    - Housing Authorities: San Diego Housing Commission, County Housing and Community Development, City of Carlsbad Housing Agency, City of Escondido Housing Department, City of Encinitas Housing Department, City of Oceanside, City of Santee, National City Housing Agency, and City of Vista Housing Department
- MHSA Special Needs Housing Program (SNHP) – includes capital and operating funds
- No Place Like Home (in late 2017/2018)
- Other possible resources, including developer equity (such as land) or private philanthropy

Behavioral Health Services Resources

Overall, it is important to scan the full range of potential Behavioral Health resources available to support services for people with mental illness, substance use disorder, or co-occurring disorders. The following local, state and federal sources are all important supports for behavioral health services in San Diego:

- California Work Opportunity and Responsibility to Kids (CalWORKs)
- City and County General Funds
- Community Mental Health Services (CMHS) Block Grant
- Community Services Block Grant (CSBG)
- County Mental Health Funding:
    - Federal Medicaid

    - Realignment
- Federally Qualified Health Centers (FQHC)
- Health Center Grants for Homeless Populations
- Homeless Veterans Reintegration Program (HVRP)
- Housing Opportunities for Persons with AIDS (HOPWA)
- Independent Living Program
- Mental Health Services Act (MHSA)
- Patient Protection and Affordable Care Act (PPACA)
- Projects for Assistance in Transition from Homelessness
- Ryan White Comprehensive AIDS Resources Emergency (CARE) Act programs
- Social Services Block Grant (SSBG)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
    - Services Grants, Infrastructure Grants, Best Practices Planning and Implementation Grants, and Service-to-Science Grants, Cooperative Agreements to Benefit Homeless Individuals (CABHI)
- Substance Abuse Prevention and Treatment (SAPT) Block Grant
- Temporary Assistance for Needy Families (TANF)
- Transitional Housing Placement Plus (THP-Plus) and THP-Foster Care
- Transitional Living Program for Older Homeless Youth (TLP)
- Veterans' Employment Program

Chapter 5: Mental Health Services Act Housing Program

The Mental Health Services Act (MHSA) Housing Program has transformed the range of housing options for people with serious mental illness in San Diego County. MHSA is funded through a 1% income tax on personal income over $1 million to be used for mental health care in California. MHSA's goal has been to transform the mental health system in California so that those who are unserved or under-served can access responsive client- and family-centered care that is oriented toward wellness and recovery. In addition, MHSA explicitly recognizes that a lack of housing for individuals with mental health issues is a barrier to wellness and recovery, and in San Diego $33 million was dedicated to the creation of new supportive housing units. The resources of the MHSA Housing Program have brought many new housing and services partners together to create unprecedented, integrated affordable and supportive housing options across the County. Since the implementation of the program in San Diego, the following results have been achieved:

- **241 units of MHSA Developed Housing:** 185 units of MHSA housing are currently open and leased up in twelve housing developments across the County, with an additional 752 units of affordable housing that are integrated with these MHSA developments. The $22 million in MHSA Housing Program capital funds is leveraging over $450 million in other funding including Low Income Housing Tax Credits, State funding (SHP, TOD, Infill, etc.) and local funding (Civic San Diego, San Diego Housing Commission, Carlsbad, Lemon Grove, San Marcos) for the development of 241 MHSA units and 1,304 other affordable housing units. A map of these developments can be found in Appendix G. In addition, Civic San Diego has adopted a requirement that a minimum of 15% of units in new affordable housing developments receiving agency funding be set aside for homeless or at-risk populations. Project based Section 8 vouchers have also been leveraged in four MHSA Housing developments.

- **668 Partnership Units across the County:** Partnering with the San Diego Housing Commission and County HCD, the County has leveraged its services funding to secure 280 sponsor-based vouchers (240 for persons with serious mental illness and 40 for persons with substance use issues). In addition, in partnership with the local Continuum of Care which oversees San Diego's application for federal Housing and Urban Development (HUD) Homelessness funding, 107 Shelter Plus Care vouchers provide housing subsidies for people served by County Behavioral Health Services.

- **Importance of Housing in Recovery:** Since FY 08-09, the County and their technical housing consultant, CSH, have conducted over 50 focus groups with MHSA FSP-enrolled clients to assess their experiences with housing and services. Consumers consistently rate quality affordable housing as one of their greatest needs. They report that housing is the foundation to live a healthy lifestyle and achieve recovery goals. Through the annual focus groups, FSP enrollees have consistently indicated that housing has helped them achieve personal goals such as working to achieve recovery, having a sense of security, the ability to work and/or go to school, and the opportunity to take care of health issues.

- **Housing MHSA FSP Clients:** The County's goal is to have at least 95% of MHSA Full Service Partnership clients living in housing. As of November 1, 2016, the FSPs had pver

90% of their clients housed with 69% of clients living in permanent housing.[25] This number represents a slight decrease from 2013 when 74% of FSP clients were in permanent housing.

FSP Clients Housing Situation as of March 1, 2017

Permanent Housing	**Number**	**Percent of Total FSP clients**
Developed MHSA Units	180	12%
MHSA Leased Units	224	15%
Shelter Plus Care	85	6%
Clients with Tenant-Based Section 8	40	3%
Clients in Other Affordable housing[26]	51	3%
Clients without Subsidy	224	15%
Sponsor Based Subsidy	163	11%
Total Clients in Permanent Housing	**967**	**66%**
Other Housing		
Clients living w/ Family/Friends	39	3%
Clients living in Emergency Housing	7	0%
Clients living in Transitional Housing	128	9%
Clients living in Licensed Facilities (Board and Care, Long-Term Care Hospital, Assisted Living, etc.)	236	16%
Other (streets, unknown living situation, etc.)	79	5%
Total Clients in Other Housing	**489**	**34%**
VI Phase 2 –SIP AOD Program	**37**	
Total FSP Clients	**1,495**	

[25] Housing is defined as emergency housing, transitional housing, permanent housing, skilled nursing facility, board and care, assisted living, and living with family/friends.

[26] In this table, affordable housing is permanent housing where the rents are subsidized to make them affordable to the tenant.

Continuing the BHS Commitment to Permanent Supportive Housing

In August 2016, the County of San Diego committed to participate in the Special Needs Housing Program (SNHP), the CalHFA-administered program that is replacing the expiring MHSA Housing Program. The MHSA Housing Program was successful in creating 241 units of permanent supporting housing, with the final developments, Atmosphere and Mission Cove, scheduled for completion in 2017 and 2018 respectively. Numerous developers have already expressed interest in participating in SNHP based on the County's current $10 million funding commitment.

The County has developed and updates annually the MHSA Special Needs Housing Program Guidelines and Recommendations (found in Appendix H). These guidelines and recommendations outline the criteria and priorities in creating new MHSA Housing in the County. New guidelines have been developed for SNHP for all development applicants moving forward.

Through SNHP, BHS also has the option to allocate funds to existing MHSA developments with a current commitment of Capitalized Operating Subsidy Reserve (COSR). In 2016, MHSA funds were allocated to the 15th and Commercial development to extend the affordability of the 25 MHSA units. While BHS will continue to pursue Project Based Subsidies for current and future developments, the option to add to COSR for existing MHSA units will help to preserve the affordability and access to these units by MHSA-eligible tenants.

While BHS has already committed $10 million to SNHP, the evolving No Place Like Home (NPLH) program represents a massive shift in the provision of supporting housing for persons with serious mental illness. While there are still many unknowns in when and how NPLH will be implemented, it will almost certainly bring a huge investment in capital development funding for San Diego County. Coupled with Project One for All, NPLH will bring unprecedented resources in the coming years to address homelessness among individuals and families who are impacted by behavioral health challenges.

Chapter 6: Behavioral Health Housing Five Year Goals

Through the work of BHS and the Housing Council, significant progress has been made in achieving the Behavioral Health Housing Five Year Goals. The following are just a sampling of successes that have been achieved in recent years:

- San Diego County's commitment of $10 million to the new Special Needs Housing Program
- Launch of Project One for All
- 100 Homeless contract, the first-ever joint RFP between the County and the San Diego Housing Commission and the first-ever BHS program that will jointly serve individuals with SMI and individuals with a primary diagnosis of substance use disorder
- Implementation of a pilot Moving On program in partnership with the San Diego Housing Commission
- Creation of the Home Finder program that will provide housing search assistance for people accessing BHS outpatient services that are experiencing housing instability

This Behavioral Health Housing Plan outlines the following Five Year Goals in seeking to maximize housing options for people with behavioral health issues and limited means in the County of San Diego. Each key goal area includes identified strategies and activities to pursue over five fiscal years that are outlined in detail in the Housing Work Plan FY 16-17 (Appendix A). The Work Plan outlines the process of evaluating progress against the goals and opportunities to make mid-course adjustments as the strategies and activities are implemented. The six Goals 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 Housing Council Work Group will review and update the Work Plan on an annual basis to prioritize the implementation of this plan and to assess the effectiveness and outcomes on an ongoing basis. In this time of political uncertainty, the Housing Council and Work Group will search for creative strategies to maximize resources in a continued effort to realize the goal of safe and affordable housing for persons with serious mental illness.

Strategies will expand upon current work to leverage local, state, and federal funding opportunities; build partnerships with regional housing and service providers; and explore new service models that link individuals receiving behavioral health to housing resources. Significant progress has already been made and sets a strong foundation to continue these efforts. The Housing Council and Work Group will also continue to promote the message that housing is healthcare and plays a vital role in the recovery process for persons with behavioral health challenges.

The timeline below illustrates key accomplishments and future goals that are described in greater detail in the Housing Work Plan.

Chapter 7: Annual Review and Update

This Behavioral Health Housing Plan is designed as a living document that is updated to chart progress toward the Plan's goals, and the changing dynamics in the County. In addition, the MHSA Housing Program Guidelines and Recommendations will be updated to ensure any new MHSA housing developments are responsive to tenants needs.

An annual Work Plan will be developed through the Behavioral Health Housing Council Work Group to map out the specific annual priorities and activities in any given fiscal year and the Work Group will chart progress against the plan. In addition, San Diego Behavioral Health Services Administration and the Housing Council will review and evaluate the Behavioral Health Housing Plan and the year's accomplishments at the end of each fiscal year.

Appendices

A. Housing Work Plan FY 16-17
B. FSP and MHSA-Developed Unit Focus Group Summaries
C. Behavioral Health Housing Survey & Housing Agencies and Consumer Resources
D. Behavioral Health Housing Survey Summary (NAMI)
E. MHSA Housing Pipeline Chart
F. MHSA Housing Developments Map
G. MHSA Special Needs Housing Program Guidelines and Recommendations
H. Glossary

Appendix A: Housing Work Plan FY 16-17

Goal 1: Expand Inventory of Affordable and Supportive Housing		Lead	Action Steps	Results to Date
Strategy	Activities			
a. Identify additional funding sources for housing development (e.g. Section 811, waiver programs, Project Based Housing Choice Vouchers)	Promote understanding of these funding sources and align local programs with eligibility criteria	CSH		Track "No Place Like Home" (NPLH). Support "Project One for All" (POFA) efforts. Track "Housing our Heroes" campaign.
b. Align services commitments with capital subsidies	• Link capital funds available through SNHP and NPLH with ongoing subsidies and services provided by contractors and County-operated programs within Adult/Older Adult System of Care • Coordinate housing and service resources available through POFA • Identify service options to match with NPLH	CSH County BHS	Regular meetings with the San Diego Housing Commission and County Housing and Community Development, as well as other Housing Authorities in the region.	• 3rd San Diego *Housing First NOFA* released in fall 2016. • Coordinated with County HCD's Housing NOFA and Special Needs Housing Program. • Closely track NPLH • Submit comments on NPLH program by 1/31/2017
c. Work with local Housing Authorities to commit additional rental subsidies to create supportive housing for the SUD population to include recovery housing	Meet with local Housing Authorities to identify Project Based Section 8 and Sponsor Based Section 8 opportunities for individuals with a primary diagnosis of substance use disorder	CSH County BHS	Regular meetings with the San Diego Housing Commission and County Housing and Community Development	BHS and SDHC Joint RFP for 100 Homeless project begins January 2017 – MHS' program called "HOMES Central."
d. Invest in the Special Needs Housing Program	Assign funds, as available, to SNHP	Housing Council	Identify this as a priority in the MHSA Planning Processes.	$10 million for Special Needs Loan Program approved 9/29/2015. Additional $10 million identified in MHSA CSS Plan.
e. Explore alternative permanent housing options (e.g. tiny houses, container houses, motel rehab)	Meet with developers to assess feasibility	ILA	Worked with D2 office re: SD RHO Active involvement with Encinitas ordinance	City Rooming House Ordinance passed in College area of the City of San Diego. Encinitas Ordinance passed but not implemented until 9th Circuit opinion.
f. Track zoning ordinances in cities across San Diego to ensure they do not limit ability to establish shared living options (Independent Living Homes, Sober Living, etc.)	Summarize zoning ordinance re: shared housing by municipality and track any proposed changes	ILA		Ordinances summarized and are being tracked. Watching Issa bill closely (H. R. 6070 – reintroduced in 01/2017).

Goal 2. Increase Access to Independent Living Options		Lead	Action Steps	Results to Date
Strategy	Activities			
a. Identify short-term rental assistance and rapid rehousing programs that can be better aligned to provide housing to the ADS/MH/DD population	Create a summary of rental assistance programs in the County and identify any barriers that would be faced by the ADS/MH/DD population	RTFH		Coordinated Entry System (CES) links people experiencing homelessness to Rapid Rehousing (short term rental subsidies).
b. Identify long-term rental assistance programs that can be better aligned to provide housing to ADS/MH/DD population	• Review Housing Authority policies (e.g. preferences in the Section 8 program) to see how they can address housing needs for this population • Embed sustainable housing subsidy funds within ongoing/expanded FSP programs	CSH County BHS Housing Council	Discuss SDHC's and County HCD's Administrative Plan language which has more flexibility in approving tenant applicants with disabilities who face housing barriers.	County HCD is exploring using HUD-VASH criteria (lower barrier) for Shelter Plus Care program. SDHC and County HCD Administrative Plans under revision (March vote; June implementation). County HCD working with BHS on initiative in East County.
c. Expand availability of housing search/placement assistance as a service for MH/ADS/DD population	Research housing placement models and strategies to be implemented by the Home Finder program	Alpha Project		Home Finder program, led by Alpha Project, implemented in fall 2016.
d. Implement landlord recruitment strategies	• Recruit a private sector landlord representative to the Housing Council • Sustain award program for landlords who are involved with special needs initiatives • Anti-stigma training for landlords • Explore flexible incentives for landlords to increase capacity for BHS clients • Advocate for the expansion of existing landlord recruitment effort to	CSH	Coordinate with Apartment Association re: annual awards event, education opportunities for both landlords and clients, and strategies to open new doors for BHS consumers.	November 2016 Awards event, with "Ending Homelessness Award" (2nd year). April 13th 2017, SDCAA Expo event. Landlord Outreach Committee established by CoC. Invite "Housing Our Heroes" to present to Housing Council to discuss lessons learned from their landlord outreach efforts.

	include tenants with serious mental illness and/or substance use disorders			
e. Reduce barriers to housing such as criminal/credit screenings	• Work with housing providers and housing authorities to educate them on housing the ADS/MH/DD population • Identify barriers to leveraging funding resources • Coordinate with Public Safety to identify housing resources for persons with criminal histories and/or persons living in the community who are under the supervision of Probation or the Sheriff's Department			• County HCD is reviewing their Administrative Plan language to identify barriers to housing in the background check process. • SDHC offers Sponsor Based Subsidy options, with reduced background check requirements.
f. Partner with Independent Livings, Sober Living Homes and residential treatment providers to educate them on reasonable accommodation policies, appeal processes, and other ways to advocate for their clients during the housing application process	• Create training curriculum collaboratively with the Independent Living Association, the Sober Living Coalition, Residential Care Committee, etc. • Increase referrals to ILA member homes	ILA Sober Living Coalition		Referrals to ILAs increasing (FSPs at 50% of clients in member ILA homes). County BHS programs actively partnering with ILA member homes.
g. Identify opportunities to expand housing options for specific subpopulations, particularly women and men with children	Summarize best practices for housing specific subpopulations (e.g. Temporary Assistance for Needy Families (TANF); etc.); children 10+ in particular			
h. Explore opportunities for centralized housing search assistance for ADS/MH/DD pop. to help providers locate and secure housing for their clients	Collaborate with local efforts to create a regional housing database			

i. Improve information/education for clients on available housing resources, particularly Housing Choice Voucher (Section 8) program (how to get on list, etc.)	Identify opportunities to provide information to clients regarding affordable housing options in San Diego County (e.g. NAMI; RI International; Clubhouses; etc.)	Housing Council Work Group, RI International, NAMI		CSH providing informational presentations to RI International.

Goal 3. Provide Opportunities to "Move On" To More Independent Housing Options		Lead	Action Steps	Results to Date
Strategy	Activities			
a. Implement Moving On pilot in partnership with the SDHC	• Coordinate with SDHC and BHS in the roll-out of the program to ensure tenant success • Advocate for additional tenant-based subsidies after the completion of the pilot program			Pilot with 25 "Moving On" subsidies launching in City of San Diego in 2017. CSH providing information to developments with Project Based Section 8 regarding "Moving On" options after 2 years of tenancy.
b. Educate Independent Livings, Sober Living Home operators & Residential Treatment providers on housing resources and programs	• Develop informational materials on housing resources • Develop strategies for greater collaboration between sober living homes and SDBHS, contracted providers, and the medical community to improve service coordination and medication management for residents (including Medication Assisted Treatment)	ILA Sober Living Coalition		ILA and Sober Living Coalition actively involved in Housing Council and identifying opportunities to collaborate and share information on resources.
c. Identify incentives for individuals living in Board and Care to move to more independent housing settings	Design and implement a strategy to assess individuals living in Board and Care and supportive housing to determine who is interested in moving on			

d. Work with Board and Care providers to admit people with high levels of need	Provide training to Board and Care staff on WRAP and other topics	RI International JFS		
e. Support behavioral health clients in supportive housing (S+C, MHSA) in moving to affordable housing	• Assess level of care needs • Identify funding sources for transition costs (e.g. moving vans, deposits, etc.) • Explore using Housing Choice Vouchers to help clients "move on" from Shelter Plus Care, MHSA units, Board and Care, etc.	BHS CSH	Continue discussing "Moving On" with SDHC.	Clients in developments with Project Based Section 8 are beginning the "Moving On" process (Cedar Gateway; the Mason) Moving On draft language under consideration in SDHC Administrative Plan.

Goal 4. Expand Opportunities to Increase Income (Employment and Benefits)		Lead	Action Steps	Results to Date
Strategy	Activities			
a. Explore opportunities for ADS and MH providers to partner with mainstream employment resources (such as San Diego Workforce Partnership (SDWP)) as well as focused initiatives (e.g. Fairweather Lodge).	• Work with SDWP to identify employment opportunities for the ADS/MH/DD population, including identifying employment, training, apprenticeship and transportation assistance • Explore the expansion of focused initiatives, such as increasing the number of Fairweather Lodge projects	SDWP		Series of three Supported Employment trainings offered in March. All BHS providers offering employment services are represented. Data Book for FY 15/16 shows 400+ more clients actively employed and also 400+ clients actively looking for work.
b. Align Housing Planning efforts with Supported Employment Strategic Planning efforts	Active collaboration between Housing Council and Work Well Committees and planning efforts	Housing Council		Housing Council representative regularly attends Work Well meetings.

c. Explore opportunities for ADS and MH providers to partner with mainstream benefits providers to provide assistance in applying for Supplemental Security Income (SSI) and other benefits.	Continue to support participation in benefits assistance efforts (Legal Aid; Clubhouses; HOPE San Diego; etc.)			

Goal 5: Lessen Isolation and Keep People Connected to Their Communities		Lead	Action Steps	Results to Date
Strategy	Activities			
a. Link residents in permanent supportive housing, Board and Care, Independent Living, Sober Living, and other housing options with NAMI's Helpline, MHS' warm line, peer advocacy programs, etc.	Promote services offered by NAMI, RI International, MHS, etc. with landlords, Board and Care operators, Sober Living providers, etc.	NAMI RI Internatio al MHS		Property Management staff (e.g. BRIDGE) requested and completed Mental Health First Aid training.

Goal 6. Develop Improved Data Collection and Analysis Capacity		Lead	Action Steps	Results to Date
Strategy	Activities			
a. Align housing status categories & definitions in BH data systems with categories used in Homeless Management Information System (HMIS) to improve understanding of the MH/ADS/DD and homeless populations and how they overlap	• Work with the County to review housing categories in the ADS Data Book and explore the feasibility of incorporating categories that correspond to those in the HMIS • Raise awareness of need for research regarding the management of opiate medications in various settings; as well as research on the outcomes of various housing models and programs that allow for relapse			Refer to FY 15/16 DataBook
b. Coordinate and collaborate with San Diego County Continuum of Care as they develop a new system for coordinated entry, assessment and	• Ensure the BH Housing Council representative for regular Continuum of Care (CoC) Meetings aligns Housing Council efforts with the CoC	BHS CSH	CSH regularly attends the quarterly CoC meetings BHS, HHS and CSH	BHS and CSH attending combined Design Team meetings. 25 Cities now incorporated into the

referral for homeless people to ensure it is aligned with goals and objectives of the Behavioral Health system	Coordinated Entry System (CES) efforts • Work to align with CES/25 Cities efforts, such as how to effectively receive referrals from the CES system.		regularly attend a variety of 25 Cities meetings.	CoC organizational structure. CSH and BHS will participate in various newly established CoC committees (especially CES) CES presentations to various FSP/Housing meetings.
c. Coordinate with criminal justice stakeholders to advance data sharing efforts to serve persons with SMI who are involved with the criminal justice system	• Coordinate with County of San Diego Public Safety Group to implement data sharing strategies to better serve persons with SMI who are under the supervision of Probation or in Sheriff's Department custody • Advocate for the sharing of health, housing and criminal justice data in coordination with County data sharing efforts	CSH HHSA PSG		

Appendix B: FSP and MHSA-Developed Unit Focus Group Summaries

Mental Health Systems, Inc.
North Star ACT Program
Housing Focus Group Summary
March 17, 2016
13 participants

1. **Are you satisfied with your current housing accommodations?** The majority of the focus group participants were very satisfied with their housing. This includes participants that had their own apartments and participants who were living in master leased units and had a roommate. The only participant that expressed dissatisfaction was in an Independent Living Home (ILH).
   - Several participants said they were happy living with a roommate, and the program did a good job helping to match roommates.
   - One participant who lives with a roommate said he "*couldn't ask for anything better*."
   - One participant is very grateful for services, but is not satisfied with the ILH and feels that this housing was assigned due to a recent relapse. Even though the participant is not happy with housing, *"[I am] grateful I am not on the street*."
   - One participant said, *"I'd be on the streets if it weren't for the assistance."*

2. **Do you feel safe in your current housing?** The majority of the focus group participants reported feeling safe in their housing.
   - *"Yes, all of my neighbors look out for each other,"* reported one participant.
   - One participant does not feel safe living at an ILH due to problems with other residents.
   - One participant say he feels very safe and can touch base with a team member and issues will be covered. *"Nothing is going to fall through the cracks."*
   - The facilitator asked if people feel unsafe, and nobody raised their hands. One participant does not go out at night, but that is more of a personal choice due to time spent on the streets.

3. **Are you satisfied with the services that you are receiving from the program?** All participants who gave feedback were satisfied with their services. Some participants report being satisfied, but would like an increase in the frequency of visits with team members.
   - *"I love my case manager…and the Psychiatrist is excellent,"* stated one participant who also explained that staff is available to meet at any time of the day.
   - NSA helped one participant to get an IHSS worker who has been very helpful, and they also adjusted the schedule for meeting with the psychiatrist to make transportation easier.
   - "*I'd like to see my case manager more often…at least every 2 weeks*." One participant has a financial issue and needs additional help.
   - One participant reports feeling overwhelmed with things he's been helped with. Good, positive people have been hired

4. **Please describe the process for getting into your housing.** Participants described a range of time frames for finding housing from 1-2 days to about a month, but the majority was satisfied with the process.
   - One participant shared that it took a while to find the right housing due to credit issues and relapses, but said that the program helped throughout the process.
   - Before entering the program, one participant was living in a very crowded sober living and did not feel safe. The participant started meeting with a NSA case worker after the hospitalization, and the case workers took care of everything and found another housing option within one day.

- Another participant moved over a 2 day period.
- One participant was at a crisis house and was connected to a case manager at NSA. Program staff helped with paperwork. *"It took about a week and I was happy with the outcome and the timing."*
- One participant does not feel that staff wants to help and does not think that this is the right program.
- One participant started with another program, but came to NSA and the process moved quickly. After being homeless for a few years and living in bad situations, NSA quickly identified other housing. NSA has respect and compassion and *"they don't take advantage of my disadvantage."*
- One participant said was finding housing was a good experience, but it was a process. It took a long time, but *"it was worth the battle."*

5. **Do you have the opportunity to provide feedback regarding your housing to the program?** The majority of participants reported that they are able to provide feedback and that the program is responsive; however, a few participants reported that the program is not responsive to feedback and issues with housing.
   - One participant does not feel that staff treat everyone the same when there are problems.
   - *"Sometimes they listen, sometimes they don't,"* responded one participant who also felt that the program does not offer enough different options when people are dissatisfied with their current housing.
   - *"Yes, always opportunity to provide feedback through multiple channels,"* responded another participant. *"They [program staff] want to be on top of their game, so I want to be on top of the game."*
   - One participant stated that the housing is excellent and he has no issues to report.
   - One participant reported that maintenance problems can take a long time to be addressed.
   - Participants provided the following written feedback:
     - *"Problems are taken care of quickly."*
     - *"They show much concern for my safety and well-being."*

6. **Has the program helped you to find alternate housing if you are not satisfied with your current housing?** Most participants were satisfied with their housing and therefore did not have feedback on the question. Some participants reported issues with housing when they first entered the program.
   - One participant stated that the program staff "*always let me know what other options are available."*
   - One participant agreed that the program would help to move, but the program does not have a list of ILHs.

7. **Is there anything else about your housing situation that you would like us to know about?** Overall feedback on housing was very positive.
   - One participant stated, *"I'm happy as can be."* The only issue is that the laundry is a little far.
   - Participants provided the following written feedback:
     - *"Where I just moved to is nice and just excellent."*
     - *"I'm very satisfied where I'm at."*
     - *"I have the best roommate…and we have the best landscaper."*

Pathways Community Services
Catalyst Program
Housing Focus Group Summary
March 29, 2016
9 participants

1. **Are you satisfied with your current housing accommodations?** Most participants reported being satisfied with their current housing. The most common complaint related to issues with staff at independent living homes. Participants at Mulberry Ranch shared the following:
   - One participant appreciates that they *"don't kick you out if you mess up. They give you chances and they show that they care."* The only complaint was the House Manager who is *"disrespectful and really snappy*."
   - Another participant also lives at Mulberry Ranch and said that the IL provides transportation to the store and to the trolley station and shared that there have been no issues with other residents or staff.
   - Another Mulberry Ranch resident described it as a *"good place,"* but also shared that *"sometimes the House Manager is nice and sometimes he's mean."* The participant feels that the owner could do more to address issues with problematic residents and the behavior of the House Manager. Despite these issues, the participant thinks Mulberry Ranch is doing more than other ILHs.
   - Another participant at Mulberry Ranch said the *"House Manager did cross the line" and* described a conflict with the House Manager. The participant also shared that *"other than the House Manager, it's great*." The participant feels like the owners listen to what the residents have to say, and they are able to provide transportation. One thing to improve is that they are not open to suggestions on changes in activities for the residents and suggestions to improve the food selection for people with a healthier diet.

   Participants residing at other locations shared the following feedback:
   - One participant shared that "*without the ILF, I'm homeless."* However, the participant did not feel like the house manager enforced house rules fairly and consistently for all residents.
   - One participant at an independent living says it's nice and quiet, but the location is just alright because things are far away

2. **Do you feel safe in your current housing?** Participants had mixed responses on safety. Some participants expressed a desire for more safety features like cameras, while others felt it was an invasion of privacy. Some participants felt threatened by other residents or ILH staff. Most participants felt like the neighborhood where they live is safe.
   - One participant stated that *"they [owners] have cameras, but they don't check and just blame it on people that have had issues before."* The owners don't live on the property; the participant thinks it would be safer if they checked the cameras more frequently.
   - One participant reports feeling safe, but said that the ILH staff does not respect his privacy.
   - Two participants report feeling safe, but do not feel that their belongings are safe and secure.
   - Another participant said that his ILH was located in "*definitely a safe area."* He also said that *"everything is secure and premises have cameras."* At the same time, it *"can feel like security measures are too much,"* and you don't have your own space.

3. **Are you satisfied with the services that you are receiving from the program?** Participants provided positive feedback on the program as a whole, but five participants expressed dissatisfaction with a male doctor who the participants felt overprescribed certain medications and was not responsive to client feedback. Several also felt like they were not able to meet with the doctor as frequently as they would like. Three participants would like more information about benefits like SSI and CalFRESH.

- One participant shared that *"they do everything that they're supposed to do."* The participant was glad to meet with another doctor who did not think the participant needed as much medication as before.
- Another participant responded that the services were going well.
- One participant asked to schedule a walk-in with another doctor because the normal doctor always prescribes new medications. The participant wants adjust to medications and wants to provide more feedback. The participant went to another doctor because of negative side effects associated with the medication he was taking before.
- Another participant agreed that the doctor overprescribes medication and gives incorrect doses. The medication made the participant drowsy and anxious and led to other serious side effects. When the participant expressed concerns, the doctor did not respond appropriately. For three years, the participant was "*forced to take a medication I did not want to take."*
- One participant shared that staff don't provide information on side effects of medications and help participants keep an eye out for side effects.
- While several participants had specific complaints, the facilitator asked people to raise their hands if they were dissatisfied with the program, and nobody raised their hands.

4. **Please describe the process for getting into your housing.** Most participants described finding housing in a short time frame with good communication from the program.
   - One participant was referred to Catalyst while in rehab. The participant was promised housing after 3 months and got housing after 4 months. The participant said the program was kind and responsive during the housing process.
   - One participant joined Catalyst, had 2 meetings with staff, and had housing within a few weeks. The participant said the program staff was communicative.
   - Another participant described a challenging situation with family. The participant set up an appointment to meet with Catalyst and filled out paperwork with team members. After a short time, Catalyst provided 2 housing options. *"Being flexible helped me out a lot."*
   - One participant got into the program right away from a homeless shelter, and it took about a month, and *"as soon as I got into Catalyst I had a place to stay."*
   - Another participant learned about Catalyst in the hospital. The program was really supportive, and the participant has not been to the hospital since joining Catalyst

5. **Do you have the opportunity to provide feedback regarding your housing to the program?** Most participants felt that they could go to the program when they had housing issues.
   - One participant shared that the program will help to find a better place if there is a problem.
   - *"When you tell them the issues about the housing… they respond to you and stick up for you."* The participant felt that ILH owners will blame residents, but Catalyst will advocate for clients.

6. **Has the program helped you to find alternate housing if you are not satisfied with your current housing?** All participants reported that the program is helpful in providing alternate housing.
   - One participant shared that Catalyst gave the option to enter a crisis house instead of the hospital.
   - Another participant shared that the program staff "*definitely take their time to do their research to find a place that is best suited for each individual."*

7. **Is there anything else about your housing situation that you would like us to know about?**
   - One participant thinks that ILHs should provide basic necessities to residents to prevent theft.

Community Research Foundation
Senior IMPACT
Housing Focus Group Summary
March 30, 2016
9 participants

1. **Are you satisfied with your current housing accommodations?** Participants living in their own apartments were satisfied. Participants living in more transitional housing, such as hotels/motels and independent living homes, expressed less satisfaction. Feedback from less satisfied participants includes the following:
   - Some participants expressed concern about safety and maintenance issues at their transitional housing.
   - Some participants expressed concerns about the cost of housing.
   - Some participants expressed concern about sharing space with other residents and the small size of personal space.

2. **Do you feel safe in your current housing?** Most participants described feeling safe where they live. Only one participant described feeling unsafe, and others described measures taken by property management to increase their safety. All participants report feeling safer in their current housing than other housing or homeless situations before entering the program.
   - One participant shared that property management is installing cameras where she lives. She doesn't think there will be problems, but the cameras make her feel a lot safer.
   - Another participant likes that there is a security guard at night on the property.
   - Another participant feels safe but would like better lighting
   - Two participants shared that they would like property rules to be better enforced when there are issues with other tenants.

3. **Are you satisfied with the services that you are receiving from the program?** Most participants described being satisfied with the services. Two participants described issues with particular staff, and another participant would like more services to be available in the mornings. Feedback from the participants included the following:
   - *"I like IMPACT, they have really helped me out…they saved me, I wouldn't be alive today.*"
   - One participant provided written feedback that *"Senior IMPACT has been a god-send…[the staff] are well-trained."*

4. **Please describe the process for getting into your housing.** All participants described the process for getting housing as happening quickly with good communication from the program. However, several participants explained that their current housing is not ideal, and they would like to find more suitable housing for living long-term.
   - One participant explained that finding housing was *"shorter than any other place where I have applied*." Senior IMPACT got the participant into housing very quickly. *"It was really surprising that I got in that soon…I'm not really happy where I'm at, but I'm not on the street."*
   - Two participants described challenges finding the right housing, but that Senior IMPACT staff helped them move to a better place.
   - One participant got into housing fairly quickly. The participant had been with another program, and there was a good handoff between the programs. Someone from Senior IMPACT helped to fill out paperwork and the communication was good.
   - Another participant's written feedback stated that the *"process was very good."*

5. **Do you have the opportunity to provide feedback regarding your housing to the program?** Most participants felt that the program was receptive to their feedback, but that it could take time to get the desired response from the program. One participant explained that the program doesn't ask for feedback.
   - One participant explained that the program staff *"never asked me how I felt about the housing,"* but, the participant did not have any negative feedback on housing. The program has helped with different options.
   - Another participant said the program *"made every effort that they could"* to be responsive to housing needs.
   - One participant provided written feedback stating that "*Senior IMPACT staff has been 100% supportive, along with nurses and doctors."*

6. **Has the program helped you to find alternate housing if you are not satisfied with your current housing?** Most participants felt that the program would help them find alternative housing, but they would have to take the initiative first.
   - One participant is mostly satisfied, and finding new housing would be a matter of finding other places.
   - One participant described how the program helped to quickly move out of a bad situation.

7. **Is there anything else about your housing situation that you would like us to know about?** Participants describe being satisfied with housing, but several are still hoping for a more ideal living situation.
   - One participant would like housing where other tenants did not drink or use drugs.
   - Another participant described that other tenants are not respectful about noise or cleanliness.

Community Research Foundation
IMPACT Program
Housing Focus Group Summary
April 12, 2016
10 participants

1. **Are you satisfied with your current housing accommodations?** Most participants report being satisfied with their current housing. Some participants report that they like having their own place, but are dissatisfied with conditions where they live and another participant residing in a Board & Care is not satisfied with housing. Feedback from participants includes the following:
   - *"I have nothing bad to say about my housing experience."*
   - One participant shared that, with housing *"I have my privacy and freedom*" and that his home is a *"gift from God."*
   - *"I should be satisfied, but I'm not*," shared one participant who has issues with noise and suspected criminal activity among other tenants.
   - Participants provided the following written feedback:
     - *"I am happy with the location. I am unhappy about the cost."*
     - *"I love my little apartment, but it's located in a dangerous neighborhood. I am on waiting lists to get into another apartment, but if I move my monthly expenses will go up, which I cannot afford. I'm stuck!"*

2. **Do you feel safe in your current housing?** Most participants report feeling safe in their housing. Two participants live in apartment complexes that are locked, but other residents prop open the door/gate and this is a safety concern. Another participant does not feel safe in living at a Board & Care.
   - Two participants report feeling safe inside their apartments and in their neighborhoods during the day, but they do not feel safe outside at night.
   - One participant does not feel that the police respond quickly enough when there are problems and "*people leave the gate open and that makes me feel uncomfortable."*
   - *"Personally, I feel physically safe"* shared one participant, but other residents prop open the doors and this makes the building unsafe for other residents.
   - Two participants say they feel safe because the neighbors look out for each other.

3. **Are you satisfied with the services that you are receiving from the program?** Most participants report being satisfied with the services, but many stated that they had challenges getting in touch with the duty worker and reaching a live person when they called. Most reported that calls were retuned within 24 hours, but they felt that 4-6 hours would be more appropriate.
   - One participant would like the psychiatrist to make home visits.
   - Several participants shared that they are very satisfied with services.
   - All of the participants had varying levels of difficulty contacting staff. Participants reported having difficulty reaching a live person when they call for the duty worker as it always goes to voice mail. They want to talk to a person. It causes frustration and "*it's hard to be objective because you have been waiting to talk to someone*." One participant will call ahead of time if she needs something because she knows that it takes a while to get back from people. Another said she will not call in the morning because the staff is always in meetings.

4. **Please describe the process for getting into your housing.** Participants described a very straightforward process for getting housing.

- One participant was living in very bad conditions when entering the IMPACT program, but the program found new housing and, "t*hey had everything I needed when I moved there."* It took about 3 months total.
- Another participant said it took several months to get into the program, and the staff did a good job communicating. The participant lived temporarily in an ILH and then opted for the first permanent housing option offered by the program. The participant continues to be satisfied there.
- One participant said it was "*pretty easy to get in*," but was initially placed in an unsatisfactory ILH. IMPACT moved the participant to another ILH, and it took about 6 months to find an apartment. The participant thinks complaining about the ILH moved the process along faster.

5. **Do you have the opportunity to provide feedback regarding your housing to the program?** Several participants reported being satisfied with their housing and did not have feedback on this question. The feedback from the participants that did respond was mixed.
   - One participant stated "*there were times that I thought the program wasn't taking me seriously about issues with neighbors*."
   - Participants provided the following written feedback:
     - "*I never thought to ask or mention anything*."
     - *"Some of my lamps and on/off switches do not work properly."*

6. **Has the program helped you to find alternate housing if you are not satisfied with your current housing?** Most of the participants reported that this was not a problem as they are satisfied with their current housing.
   - One participant is discussing alternatives. He wants a 1-bedroom apartment in a specific neighborhood, but is open to other options.

7. **Is there anything else about your housing situation that you would like us to know about?**
   - One participant would like a family member to live with them.
   - One participant was glad to participate in the focus group because *"I learned that I can ask more questions and I can be more proactive for help to resolve some things."*

Mental Health Systems, Inc.
Center Star ACT
Housing Focus Group Summary
April 20, 2016
14 participants

1. **Are you satisfied with your current housing accommodations?** Participants provided mixed feedback on their housing accommodations. Many were satisfied with the actual housing, but had concerns about maintenance and safety issues. Other reported issues with staff turnover and a lack of communication from program staff. Several current and former residents at Utah St. had complaints about safety and maintenance issues there.
   - One participant said that ILH staff makes racist remarks and inappropriate comments about people with mental illness and has talked to the program for other housing. The participant thinks people who are more stable should not be placed into housing with people who are struggling with their mental illness.
   - One participant is happy with housing. When the participant moved, the team made a list of things to be worked on and they made repairs and improvements. The participant shares a house with a roommate and is very satisfied.
   - Another participant currently lives alone. The participant is more satisfied in now than in previous housing, but has asked for numerous repairs and has not gotten a response from CSA.
   - One participant described a situation with another resident that made housing unsafe. CSA *"assessed my situation and found what would be best"* and the participant found better housing. While the participant is happy with the current housing, it took a long time to find new housing. During this search for new housing, there were many different housing coordinators. The participant would speak to a housing coordinator about an issue, the person would leave the program, and nothing would happen. The participant thinks that the program needs to do something about the staff turnover issue and needs to assess client needs and place people in the right kind of environment.
   - Another participant at Utah St described long-standing maintenance issues. The participant was frustrated by the slow response from staff.
   - One participant shares that you have to be irate to get attention.
   - Another participant feels that CSA staff will pass issues off to other housing staff.

2. **Do you feel safe in your current housing?** Participants provided mixed feedback on safety issues and reiterated concerns around follow up on maintenance. Other participants had concerns about their neighborhoods and issues with roommates and other residents.
   - One participant shared, "*I would like bars on my house"* since the apartment was broken into before.
   - Another participant stated, *"I feel safe in my neighborhood."*
   - One participant feels safe, but knows that sex offenders have been released into the area. There are also issues with people that congregate in the alley. Otherwise, the location is good and quiet.
   - Another participant is concerned that the neighborhood has the appearance of being unsafe.
   - One participant who lives in an ILH says the house is nice, and the neighborhood is ok, but there are too many people living there.
   - Another participant had a roommate who was using substances and did not feel safe. *"I was real quiet and clean and sober…I had no room for messing up but other people in my housing were going to make me mess up*."

3. **Are you satisfied with the services that you are receiving from the program?** Participants expressed frustration at the level of turnover among housing staff at CSA and the lack of follow up from

staff. While several participants had positive overall comments, there was negative feedback about turnover, inappropriate behavior by certain staff, and lack of individualized attention.

- "*Staff members are completely overwhelmed,"* shared one participant.
- Another participant shared that *"[they] rotate staff members in and out of this place."*
- Another participant is satisfied with services and "*stays in touch with Miss Melanie."*
- One participant "*would like to be case managed more closely"* and would like CSA staff to visit and check in more frequently.
- Another participant shared that *"I am very grateful for the program and always speak highly [of the program]…my family knows this program changed my life."*
- One participant wants "*more case management one-on-one and visits so I can resolve some of my problems*." Because of the lack of follow up, "*I end up getting distracted and lose my positive look toward things."*
- "*Staff can be rude*," shared one participant.
- One participant said that staff that has been at CSA longer will have a "*long heart to heart"* with clients.
- *"We don't know these new people,"* shared one participant describing the new housing staff, adding that they are "*lacking compassion and caring."*
- *"Staff needs to learn to deal with us appropriately,"* stated another participant who feels that the staff are not trained properly, and then move on when they get some experience
- Another participant shared that it can be difficult to reach staff so it's best to come to the office and talk in person.
- Another participant is *"grateful for a roof over my head and people to help me accomplish my goals."*
- Based on the feedback from the group, the facilitator asked if participants had issues because of staff turnover and 9 participants raised their hands. He asked if participants had issues with communication and 6 participants raised their hands.

4. **Please describe the process for getting into your housing.** Participants were satisfied with the process for getting housing.
   - One participant was referred by probation, was interviewed, and within 8 days, moved from a motel to an ILH. The participant moved again and is now in a shared apartment. The participant thought "I *would be in transition for 1 year, but it was quick."*
   - One participant filled out paperwork to move into an IL with a single room. It only took one day because they had a vacancy.
   - CSA staff picked up one participant from jail, and the participant was in a sober living within a week. The participant then found a place within a week after that.
   - Another participant signed papers and "*it didn't take be long before they transferred me to housing.*" The participant wants to be in a sober environment.
   - One participant provided written feedback where she described a difficult living situation and a lengthy response time from CSA to resolve the issue and find new housing.

5. **Do you have the opportunity to provide feedback regarding your housing to the program?** Participants stated that they can provide feedback, but it can take a long time to see follow through.
   - One participant was having physical health issues, and eventually got help from the program.
   - Another participant shared that "*after a long, rigorous road of getting them on the phone or coming in to the office, they will help you."*
   - After getting out of jail, *"they gave me what I needed to be successful…and I became a success story."*

6. **Has the program helped you to find alternate housing if you are not satisfied with your current housing?** There was limited time to cover this question, but earlier in the focus group, one participant shared *"if you're not happy where you are, you can find something else."* Another participant provided written feedback about a challenging roommate situation and how the program helped to get a new place.

7. **Is there anything else about your housing situation that you would like us to know about?** Participants expressed that they want more consideration of client needs when evaluating housing options, especially as it relates to substance use and level of acuity of mental illness. They also reiterated concerns about maintenance issues and the need for better communication with staff.
   - *"They need to be aware of where they place people*," shared one participant who had a history of substance use. This participant would prefer housing where there is zero tolerance for drug and alcohol use.
   - *"Just because I have a mental illness doesn't mean I'm stupid or crazy,"* shared another participant who thinks that landlords think that they can do anything and not follow through on promises.
   - "*Program painted over mold and mildew in window just to pass inspection*," stated another participant.
   - Several participants provided written feedback indicating that they want better communication with the program.

MHSA-Developed Housing
15th & Commercial, Cedar Gateway, Connections, Parker Kier, Citronica II
Housing Focus Group Summary
April 22, 2016
19 participants

1. **Are you satisfied with your current housing accommodations?** Several participants reported significant concerns with their housing. Cedar Gateway residents are primarily concerned with safety, but also report maintenance issues on the property. They provided the following feedback:
   - There have been issues with turnover with the property management staff, and we just have a part-time maintenance person, and the place is just kept moderately clean. The participant also added that "*I love my apartment, but security has always been a problem."*
   - One Cedar Gateway shared that homeless people are coming in and out, and it is a security problem. The front door needs to be fixed so it will close automatically.
   - Another resident is extremely frustrated with ongoing security issues. She also expressed frustration about the staff turnover, "*We don't even have a manager."*
   - "*I don't feel safe*," shared one resident. *"People are selling drugs on my floor."*

   15th and Commercial residents provided the following feedback:
   - Several residents think security needs to do more about visitors and unauthorized people entering the property.
   - Another resident at 15th and Commercial has had items stolen but doesn't want to confront other residents and thinks the issue is visitors to other units.
   - Several residents are concerned that the hallways are dirty, vents are not cleaned, and pest control should be increased.
   - One resident said that is has taken too long to make repairs due to water damage from the fire.

   Residents at other developments provided the following feedback:
   - A resident at Parker Kier wants to know when carpets will be cleaned.
   - Another Parker Kier resident is concerned about homeless people entering the building.
   - A resident at Connections says it is very nice, clean, safe, and they have air conditioning. They have security onsite, but no parking.
   - One participant said that "*If I call IMPACT and tell them I have issues with management, then they take care of it…IMPACT gets it done for me*." The participant documents any issues, writes dates and takes pictures, so there is a record of problems.

2. **Do you feel safe in your current housing?** Residents at Cedar Gateway do not feel safe. One Parker Kier resident has safety concerns, but another resident does not.
   - Several residents at Cedar Gateway agree that there are security issues with people who are homeless that get in the building, drug activity, and security cameras that do not work.
   - One resident at Cedar Gateway said, *"I feel like I can't leave my apartment*."
   - One resident from Parker Kier said, *"I'm safe and I love my building"* except for the plane noise.
   - Another resident at Parker Kier would like to have a Neighborhood Watch program because there have been break-ins. The participant thinks that other residents are using drugs.

3. **Are there resident services/activities that are offered on-site and if so, are you satisfied with the services/activities that are offered?** Most residents are satisfied with onsite services, but residents at Cedar Gateway would like more access to the community room.
    - A resident at Parker Kier does not often participate in activities, but shared that "*when I do participate I feel welcome and comfortable*." The participant would like Parker Kier to allow pets.
    - One Parker Kier resident enjoys the groups and events like the art show.
    - One Cedar Gateway resident enjoys the onsite services and potlucks. The only issue is security.
    - At Cedar Gateway, the "*community room is locked constantly.*" The participant would like IMPACT to do groups onsite, but they are not allowed to use the community room.

4. **How was the application process for the unit you occupy**? Most residents described an efficient application process. Residents who moved into Cedar Gateway when it first opened were not pleased with all the delays, but they have discussed this at previous focus groups.
    - A resident at 15th and Commercial said, "*Senior IMPACT really went out of their way for me*." Staff has gone above and beyond. The new manager seems really good, and, *"I had a hard time getting in touch, but I understand because he's new."*
    - One resident had numerous hospitalizations, and Senior IMPACT has always provided support.

5. **Are the policies/rules where you live clearly explained to you**? **Are property management/maintenance issues addressed in a timely manner?** Residents from Parker Kier expressed frustration about the smoking policy. Cedar Gateway residents felt that policies were not enforced due to the turnover in management staff.
    - Parker Kier residents shared that the property was changed to non-smoking and felt this was unfair.
    - Another Parker Kier resident would also prefer that notices/rent receipts not be stuck on doors as this is a violation of privacy.
    - A Cedar Gateway resident described a situation where she was charged a fee due to lack of communication between the management staff.
    - Participants provided the following written feedback:
        - *"No one abides by the lease. They do maintenance when they feel like it."* (Cedar Gateway)
        - *"[Policies] are explained but not enforced."* (Cedar Gateway)
        - *"Management is great. He helps you all the time."* (Parker Kier)

6. **Do you feel a part of the community in your building? Do you feel a part of the neighborhood?**
    - A resident at 15th and Commercial does not like the neighborhood, but "*seeing homeless people gives you a sense of perspective."*
    - Being in a new community inspired one participant "*to step up and change my ways."*
    - A Parker Kier resident provided written feedback: *"I like my neighbors in the building. No problems*."

7. **Is there anything else about your housing situation that you would like us to know about?**
    - One resident at Cedar Gateway would like services to help deal with end of life issues; residents "*need additional resources to help with friends pass away."*
    - A resident at Cedar Gateway shared that key fobs are not helping because people can steal them and you have to pay $50 if you lose it.

MHSA-Developed Housing
Mason, Celadon, Paseo, 34th Street, Citronica I
Housing Focus Group Summary
April 27, 2016
6 participants

1. **Are you satisfied with your current housing accommodations?** Overall, the participants were satisfied with housing at all of the developments represented at the focus group.
   - A Celadon resident likes that it's near public transportation and appreciates that the community room gives you something to do.
   - A Paseo resident likes that the location is close to shopping, restaurants and the trolley, plus the apartment is "*really, really nice."*
   - On 34th Street resident thinks it is a very comfortable environment and likes the location. Everyone in the community is like a family. There is no onsite property management, but there are resident meetings. *"I love it there, it's an awesome spot."*
   - *"For the most part, I'm happy with Celadon*," responded another participant. "*Armando the manager is cool and Oscar the maintenance guy is nice and you can go to them with concerns*." However, the participant reported having issues with people accessing certain floors of the building. (Note: This issue has been resolved by Celadon.) Another issue was during the inspection where the participant was not aware of certain rules. "*Everything is in walking distance. The location is the best*."
   - *"Celadon is the most comfortable apartment I've lived in*" shared one participant. The staff is really helpful.
   - A resident from the Mason said that the manager keeps the place clean, staff is really easy to get along with, and maintenance issues are addressed quickly. The participant "*can talk to manager…manager is a good guy and I like him."*

2. **Do you feel safe in your current housing?** Overall, participants report feeling safe in their housing and stated that incidents are being dealt with by management.
   - One Paseo resident was a victim of a violent act. The participant stated that management "*have been really helpful in making me feel more safe*."
   - At 34th Street, one resident reports that one of the gates doesn't close automatically. It has not been too much of a problem, but sometimes people do cut through the property from the alley. "*I told staff and they will work on it*." Other than that, the participant feels safe in the neighborhood.
   - One resident described Celadon as a "*high security establishment*." There is security onsite, and residents have fobs. "*The neighborhood is a party scene but I don't feel threatened."*
   - One Celadon resident described that other residents let in guests that cause problems. The resident also has concerns about the neighborhood. "*I don't go out at night because it's sketchy…In my room I feel fine*." The management is aware of security issues. Despite these concerns, the participant shared that overall it feels pretty safe.

3. **Are there resident services/activities that are offered on-site and if so, are you satisfied with the services/activities that are offered?** Residents like the on-site services that are provided and made suggestions for additional class offerings and evening/weekend programming.
   - One Celadon resident shared that Project Access is a "*really good program,"* and has been very helpful with resume and interview preparation. The participant wishes they had video games on game nights.
   - Project Access is also at Paseo, and offers ESL classes, budgeting, cooking, and Zumba. One complaint is that events have been rescheduled or moved at the last minute.

- One Celadon resident would like to have Spanish as a second language classes offered to better communicate with other residents.
- At 34th Street, they have events at all the major holidays in the courtyard.
- One Celadon resident is not able to go to activities because they are scheduled during the day. The participant would like to see some evening or weekend activities for people that work.
- A Mason resident said that they have a nice community room with a flat screen TV, as well as a computer room that is accessible Monday - Friday. The participant likes having this space available to "*hook up with some friends, so I don't have to be by myself.*"

4. **How was the application process for the unit you occupy**? Several participants described their application and move-in process as going smoothly, but others described changes in the timelines and redundancies that made the move-in process more difficult.
   - A resident from 34th Street stated that the process went well. "*They told me what I needed, so I brought back the forms…they helped me with the application, and they explained the things I didn't understand.*"
   - A resident from Celadon shared, "*it wasn't horrible, but the timeline was really unclear*." The participant was not aware of certain requirements until right before move-in, and there was an issue with the participant's service animal. It would be nice if the property had a dolly for moving heavy things.
   - *"IMPACT was with me 99% of the way there*" and helped with meetings and paperwork for a Celadon resident. IMPACT had a moving van, so there was no issue with the move-in. The participant had to complete the same paperwork twice, and it was redundant, but IMPACT provided assistance.
   - Another Celadon resident said the paperwork was quick and easy, and IMPACT helped.
   - At Paseo, a resident explained that the timeline kept changing, and there was not much time to get ready to move. Up until that point, "*staff seemed very organized and nice and paperwork was all lined out*." Mike from Catalyst helped to explain certain things.
   - At the Mason, the resident said that the application and move-in went smoothly with assistance and good communication from IMPACT.

5. **Are the policies/rules where you live clearly explained to you**? **Are property management/maintenance issues addressed in a timely manner?** Some participants would like more parking and think that maintenance should address issues more quickly.
   - A participant who lives at Paseo had some issues with maintenance at the property, "*some things are fast and other times they are not*." There is not enough parking with only one vehicle per unit and only 3 visitor spots. There is not enough parking for guests, and cars have been towed. Another issue is that fire alarms go off, and it can take up to 20 minutes before the fire department show up and turn them off.
   - A Celadon resident also has a problem with the lack of visitor parking, and there was an issue fire alarm in the unit. Even though Celadon followed up quickly, the alarm was keeping her up and was very disruptive, and the participant wishes they would have just replaced it at first.
   - Another Celadon resident does not like that he cannot use stairs because the elevator is really slow, but regarding rules and policies, "*everything is in the contract, it's really clear.*"
   - At 34th Street, management will come and check it out, will not fix things right away because they have to take it to Townspeople, but issues are fixed within a few days. "*I can't say anything wrong*."

6. **Do you feel a part of the community in your building? Do you feel a part of the neighborhood?** Participants who have lived at their apartment longer feel like part of the community and newer residents are still working on it.
   - One 34th Street resident shared that it's a quiet community where residents "*all look out for one another*."

- A Celadon resident feels mostly part of it, but needs to learn Spanish to say hi to people. The participant does not think that people in downtown are friendly.
- A resident from the Mason gets along with all the neighbors.

7. **Is there anything else about your housing situation that you would like us to know about?**
   - At 34th Street, the participant would like more than just seasonal activities, like aerobics, Zumba or yoga classes in the courtyard and more frequent movie nights. *"Not all people can get out or have family… [activities are] a way to bring the community together."*
   - A Celadon resident would like more security cameras.

MHSA-Developed Housing
Tavarua & Parkview
Housing Focus Group Summary
April 28, 2016
8 participants

1. **Are you satisfied with your current housing accommodations?** For the most part, residents are satisfied with their housing, but several Parkview residents have concerns about safety, parking, and the need for improved communication with property management.
   Parkview residents shared the following feedback.
   - One resident is torn because it's a great apartment, and "*I love the neighborhood."* It is clean and maintenance staff keeps up the place, but there is drug use and lots of traffic in and out, and management just stays in the office. "*They are really lenient. You have to do something really bad to get evicted*." The participant shared that there was a break-in.
   - *"I love the place,"* one resident commented specifically about the apartment, but says that the neighborhood does not have easy access to bus lines and restaurants. There is a lot of activity in the front of the building, and it does not feel safe, so there should be alternative places to smoke and more outdoor space for residents. There is also a lack of visitor parking. Management should be more aware of safety issues with more communication between Center Star and property management. Regarding the other residents, "W*e get along amongst ourselves."*
   - One Parkview resident stated, *"I love where I live,"* and feels that the issue with the burglary has been resolved.
   - Another Parkview resident shared that that "*maintenance is awesome*" and follows up to address issues. There are concerns about parking as there are lots of empty spots that are not available to guests.

   Tavarua residents had very positive feedback and shared the following:
   - "*I only have good things to say*." The property went through a period of "*crappy management,"* but now the "*management and maintenance staff are wonderful.*" The location 6 blocks from the beach is great.
   - Tavarua is a "*wonderful place to live."* It is close to stores, a pharmacy, a senior center and the beach. Management and maintenance are great.
   - "*I'm happy with everything and everyone*." The only complaint is a feeling of isolation because the apartment activities are geared toward to older people.

2. **Do you feel safe in your current housing?** A recent burglary is a safety concern for Parkview residents, and at Tavarua, residents feel safe on the property but have some concerns about the area surrounding Tavarua.
   - One Parkview resident shared, "*I feel safe."* However, the participant feels less safe after the recent burglary. There should be a better screening process for tenants as there is a lot of turnover among residents. The participant only sees management at inspection time and would like them to be more aware of issues.
   - One Tavarua resident would like the City of Carlsbad to install better signage to indicate that Harding is not a through street. Some cars just sit and idle and others go really fast. There are also rats in the area. Residents keep the property clean, but the City of Carlsbad needs to maintain the area around Tavarua.
   - "*I never used to lock my door*," shared a Parkview resident, but after the burglary "*I will keep my door locked*."
   - A Tavarua resident also stated that there is an issue with rats, and that homeless people sleep in bushes on nearby public property. "*Once I'm behind the gate, I'm fine.*"
   - Another Parkview resident shared, "*I feel safe,"* and added that *"I like to let in the breeze, but if go to the store, I have to close everything*." Recent events have made the participant feel less safe.

3. **Are there resident services/activities that are offered on-site and if so, are you satisfied with the services/activities that are offered?** Participants would like to see more diversity in the activities offered onsite.
    - One Parkview would like outdoor space with BBQs and events to make adults feel more comfortable. Property management distributes a calendar and says it is for all residents, but it is geared for kids.
    - Another Parkview resident sees the calendars with events and is considering the resume builder class. Property management staff also hands out information with updates on the complex. The participant would like an art or crochet class to be offered.
    - One Parkview resident wants to attend the financial planning class. There are a lot of Spanish-speaking residents, and it would be nice to have a Spanish class to communicate with neighbors.
    - A Tavarua resident is "*satisfied with indoor activities*," but wishes that physical fitness classes were offered once a week instead of once a month with more outdoor activities like playing croquet.
    - Tavarua has a big grassy area with tables, umbrellas and a grill, shared one resident. There is room for a bocce ball court, and property management has been talking about it for a while.
    - A Parkview resident likes the relaxation group where meditation, yoga, and other events are offered.

4. **How was the application process for the unit you occupy**? Most participants felt that they received support from their program in completing the lengthy application process, but some participants did not have the support they needed and found the process to be stressful.
    - One Parkview resident shared, "*Center Star was with me every step of the way*." Property management explained the requirements very clearly and communication was good. It took a month to complete the process. The only complaint the lack of "*a way to weed out the bad people*."
    - One Parkview resident shared *"I didn't know how to answer certain questions because I didn't have the help I needed."* The participant felt that Center Star was very slow, and they sometimes miss appointments.
    - "*North Star helped me do everything and it went smoothly*," shared a Parkview resident. It took about 6 months but, "*I was homeless, so I was patient*." The participant lived in interim housing before Parkview.
    - A Tavarua resident shared that Senior IMPACT "*was very helpful and answered my questions."*
    - A Tavarua resident had help from one of the managers, so it was not so overwhelming.

5. **Are the policies/rules where you live clearly explained to you**? **Are property management/maintenance issues addressed in a timely manner?** Residents at both developments had concerns about smoking policies, and there were concerns about the guest policy at Parkview.
    - A Tavarua resident said they used to have a smoking area, but the rule was changed. Now smokers have to stand on the sidewalk, but smokers should be allowed to have chairs.
    - Another Parkview resident was told that tenants can only have guests 12 days out of the year and it seemed unfair, especially for people who might have family visiting from out of town.
    - In response to the concerns about the guest policy, one Parkview resident said that you can talk to management for special permission.
    - Another Parkview resident said that the policy on work orders was changed and now work orders are completed by residents.

6. **Do you feel a part of the community in your building? Do you feel a part of the neighborhood?** Most participants report feeling part of the community to some degree. Some Parkview residents would like more accessible and affordable shopping nearby.
    - One Parkview resident shared, "*I love my neighborhood and I feel like I am part of the community."*
    - Another Parkview resident said the stores that are close by are overpriced.

- *"I like the community and can be as much as part as I want to be*," shared another Parkview resident.
- A Tavarua resident stated that "*I participant in what I want, and don't when I don't*."
- Another Tavarua resident explained that "*people in the community are really friendly."* The participant has made friends outside of Tavarua and likes going to the senior center.

7. **Is there anything else about your housing situation that you would like us to know about?**
   - A Parkview resident thinks management should talk to residents so they know what is going on, and the participant is also frustrated with issues at Center Star. There has been a decline in the quality of services, "*when I first started they did a lot for me now they leave you to your own devices."* Part of the problem is the staff turnover. Because of this, the participant is "*not sure if I should build a relationship or keep my distance*" with new staff at Center Star.
   - Another Parkview resident asked "*How can I get my program to understand that I need them?*" The participant has tried to call Center Star, and just needed to talk to somebody, but was directed to the crisis line. The turnover in staff means the participant has to repeat everything when they hire a new staff person.
   - A NSA client said that staff advocate for you, introduce you to new people, and are responsive.

Appendix C: Behavioral Health Housing Survey & Housing Agencies and Consumer Resources

Questionnaire from the San Diego County Behavioral Health Housing Council

From June through August 2016, the San Diego County Behavioral Health Housing Council is conducting a Housing Needs Assessment of people with behavioral health needs. *We would appreciate a few minutes of your time.* Please help us identify and understand your experiences finding and retaining housing in San Diego County as a person utilizing Behavioral Health Services. You may complete the written survey below or complete the survey online at: **https://www.surveymonkey.com/r/SDHousing16**

1. Please describe your age range:
   - ❑ Transition Age Youth (18 -25)
   - ❑ Adult (26-59)
   - ❑ Older Adult (60+)
2. Please describe your current living situation:

- ❑ Renting my own Apartment
- ❑ Renting an Apartment with roommates
- ❑ Living with family
- ❑ An Independent Living Home
- ❑ Board and Care
- ❑ Sober Living
- ❑ Single Room Occupancy (SRO Hotel)
- ❑ Staying with Friends
- ❑ Transitional Shelter
- ❑ I Own my Home
- ❑ Skilled Nursing Facility
- ❑ Living in Car
- ❑ Crisis House
- ❑ I don't currently have housing
- ❑ Other_____

3. How long did it take you to find your current housing? _____
4. What zip code do you currently reside in? _____
5. How satisfied are you with your current housing situation?
   - ❑ Very Satisfied
   - ❑ Satisfied
   - ❑ Dissatisfied
   - ❑ Very Dissatisfied
6. What do you like about your current housing? _____
7. If you are not satisfied, why not? _____
8. What would your ideal housing be? _____
9. If you are currently looking for other housing, what type of housing are you looking for? _____
10. What would you need in order to get the housing that you would want? _____
11. Where in the City or County would your ideal housing be located? _____
12. What amount in dollars can you realistically afford to pay? Approximately, what percentage of your income is that?

    $_____ _____%
13. Are you currently receiving Section 8? ❑ Yes ❑ No
14. Have you ever received and lost Section 8? ❑ Yes ❑ No
15. Are you on the Section 8 waiting list? ❑ Yes ❑ No ❑ I don't know
16. How many times have you reapplied to the Section 8 waiting list? _____
17. Do you find it difficult to keep your information current on the Section 8 waiting list? ❑ Yes ❑ No ❑ **I don't** know

    If No, why is your information not current? ❑ *No internet access* ❑ *I forget to update* ❑ *Other*_____

18. If you are on the Section 8 waitlist, is your Section 8 application currently up to date? ❑ Yes ❑ No ❑ I don't know

19. Do you currently have a Section 8 voucher, but are unable to find a unit? ❑ Yes ❑ No
If yes, how long have you been looking for a unit? _____

20. Are you receiving any housing rental support? ❑ Yes ❑ No
If yes, what kind of rental support? _____

NOTE: If you have questions about how to get on the Section 8 waitlist or to check that your application is current, please refer to the additional handout accompanying this questionnaire.

21. Do you believe your mental health challenges have affected your housing? ❑ Yes ❑ No ❑ I don't know

22. Have you felt discriminated against because of your mental health challenges? ❑ Yes ❑ No ❑ I don't know

23. How would you rate your understanding of Fair Housing laws?
❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ None

24. What obstacles have you encountered in your search for housing or better housing? Please describe *(select all that apply):*

- ❑ Not enough income for current rents
- ❑ Not enough income to cover 1st month and security deposit
- ❑ Not enough income to cover security deposit
- ❑ Not enough income to live in a neighborhood I would want to be in
- ❑ Not enough income to live in a neighborhood I would feel safe in
- ❑ Not enough income to live in a neighborhood that is easily accessible by public transportation
- ❑ Problems with credit check
- ❑ Problems in rental history (evictions or late rent payments)
- ❑ Problems with past criminal history
- ❑ Problems finding housing where I can have my pet
- ❑ Problems finding housing where I can have my children
- ❑ Problems finding housing where I can live with my partner
- ❑ Not enough money to buy food, if I pay rent
- ❑ Not enough money to get my prescriptions, if I pay rent
- ❑ I have a rental voucher, but I don't understand how it works
- ❑ Discrimination due to mental health challenges
- ❑ If discrimination occurred, what was the nature of it?

_____

If you faced other obstacles in searching for housing or better housing, what were they?

❑ Other _____
❑ Other _____

25. What other information would you like us to know about barriers to housing that you have experienced?

_____

THANK YOU for completing this questionnaire! Please be sure to complete only ONE questionnaire, and return by August 12th at the very latest.

There are 5 options to return the questionnaire:

- ✓ Complete the survey online at https://www.surveymonkey.com/r/SDHousing16
- ✓ Return it to the person/organization who provided it to you
- ✓ By mail to: NAMI San Diego, 5095 Murphy Canyon Road Suite 320, San Diego, CA, 92123
- ✓ If you can scan and email, please email the scanned document(s) to: information@namisd.org
- ✓ By fax to NAMI San Diego at: 858-634-6585

→ If you need an electronic version of this questionnaire please email NAMI at: information@namisd.org

→ If you have questions about Fair Housing issues, please call Fair Housing Council of San Diego at: (619) 699-5888

→ If you have other housing related questions, please call the NAMI San Diego Family & Peer Support Helpline at: (619) 543-1434 or (800) 523-5933 or e-mail the Helpline at: helpline@namisd.org

HOUSING AGENCIES IN THE COUNTY OF SAN DIEGO

Contact Information/Websites with information regarding Rental Assistance (Section 8) applications

CITY OF SAN DIEGO HOUSING COMMISSION (includes San Ysidro)
1122 Broadway, Suite 300
San Diego, CA 92101
Phone: (619) 578-7777
Waiting List: (619) 578-7305
http://sdhc.org/Rental-Assistance/Waiting-List-Applicants/

ENCINITAS HOUSING AUTHORITY (includes City of Cardiff)
505 South Vulcan Avenue
Encinitas, CA 92024
Phone: (760) 633-2710
http://www.cityofencinitas.org/index.aspx?page=387

CARLSBAD CITY HOUSING AUTHORITY
1200 Carlsbad Village Dr.
Carlsbad, CA 92008
Phone:(760) 434-2810
http://www.carlsbadca.gov/services/depts/housing/assistance/default.asp

OCEANSIDE CITY HOUSING AUTHORITY
321 North Nevada
Oceanside, CA 92054
Phone:(760) 435-3360
http://www.ci.oceanside.ca.us/gov/ns/housing/default.asp

COMMUNITY DEVELOPMENT COMMISSION O F NATIONAL CITY
Section 8 Rental Assistance Division
140 East 12th Street, Suite B
National City, CA 91950
Phone: (619) 336-4254
Fax: (619) 477-3747
http://www.ci.national-city.ca.us/index.aspx?page=141

SAN DIEGO COUNTY HOUSING AND COMMUNITY DEVELOPMENT (includes all other communities including Escondido, San Marcos, Vista, Chula Vista, La Mesa, and El Cajon)
3989 Ruffin Road
San Diego, CA 92123
Phone: (877) 478-5478
Fax: (858) 694-8706
http://www.sandiegocounty.gov/content/sdc/sdhcd/rental-assistance/application-directions.html

CONSUMER RESOURCES

Contact information for Healthcare, Services, and Housing Advocacy Resources

Housing and Service Resources - Consumer Center for Health Education and Advocacy (CCHEA)
1764 San Diego Avenue, Suite 200
Phone: (877) 734-3258
TTY: (877) 735-2929
http://healthconsumer.org/

Jewish Family Service Patient Advocacy Program
8804 Balboa Avenue
San Diego, CA 92123
Phone: (619) 282-1134
http://www.jfssd.org/site/PageServer?pagename=programs_counseling_patient_advocate
Inpatient and 24-hour Outpatient and all other services: (800) 479-2233

State Fair Hearing Appeals for Medi-Cal clients
Phone: (800) 952-5253

Community Care Licensing
Licenses and oversees both day care and residential facilities for children and adults in the State of California: http://ccld.ca.gov/
Resources for making a complaint about community care facilities: http://ccld.ca.gov/PG408.htm

2-1-1 San Diego
Connects people with community, health and disaster services through a free, 24/7 stigma-free phone service and searchable online database.
Phone: 211
http://www.211sandiego.org/

Fair Housing Program, County of San Diego
North County Lifeline
200 Michigan Ave.
Vista, CA 92084
Phone: (866) 954-3354

The Fair Housing Council of San Diego
1764 San Diego Avenue, Suite 103
San Diego, CA 92110
Phone: (619) 699-5888
http://fhcsd.com/

HUD
Filing Your Housing Discrimination Complaint Online:
http://portal.hud.gov/hudportal/HUD?src=/topics/housing_discrimination

Landlord/Tenant Rights- California Department of Consumer Affairs, A guide to residential tenants' and landlords' rights and responsibilities.
http://www.dca.ca.gov/publications/landlordbook/index.shtml

D. Behavioral Health Housing Survey Summary (NAMI)

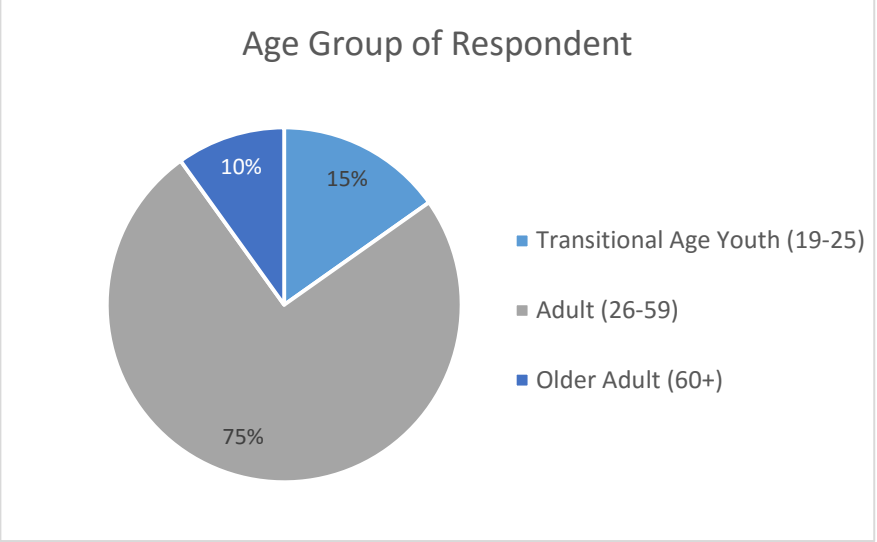
2016 San Diego Behavioral Health Housing Survey Results

Analytics by:

The following analytics stem from the survey results of 1617 respondents. 1489 of these surveys were mailed to NAMI San Diego's main office and were enetered into the online survey manually by volunteers and NAMI San Diego staff. The analytics and charts were completed by NAMI San Diego staff.

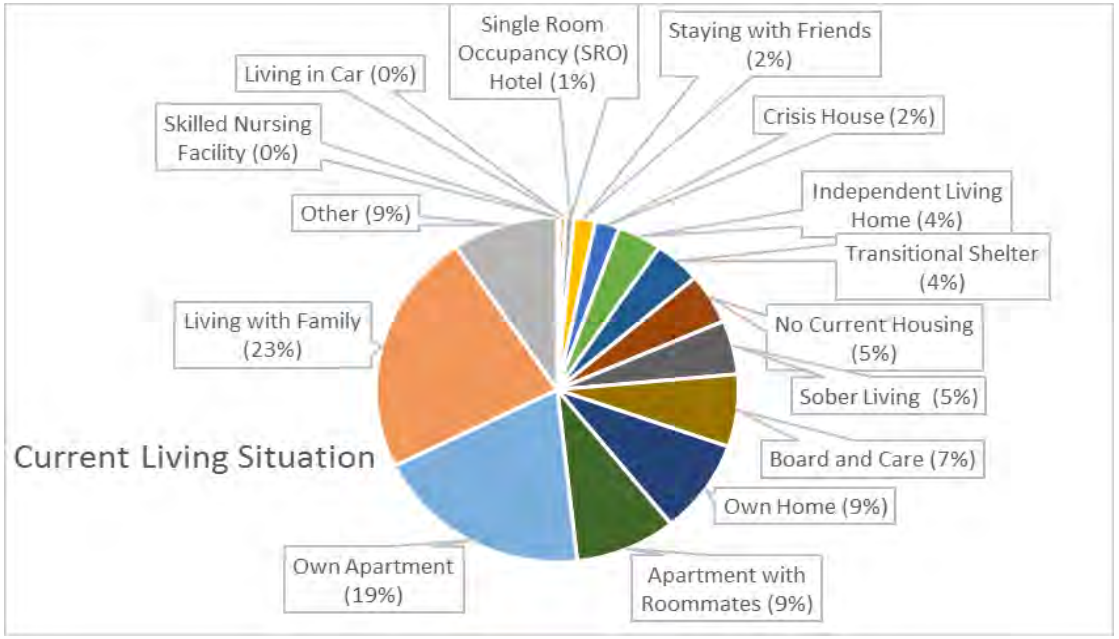
Q1: Please describe your age range:

Age Group of Respondent	Total	Percentage
Transitional Age Youth (19-25)	239	15%
Adult (26-59)	1177	75%
Older Adult (60+)	156	10%
No Response	45	



Q2: Please describe your current living situation:

Question two is the only question answered by 100% of the respondents. The majority of respondents who checked the "Other" option did so because "Renting a house" was not an option.



NAMI San Diego
National Alliance on Mental Illness

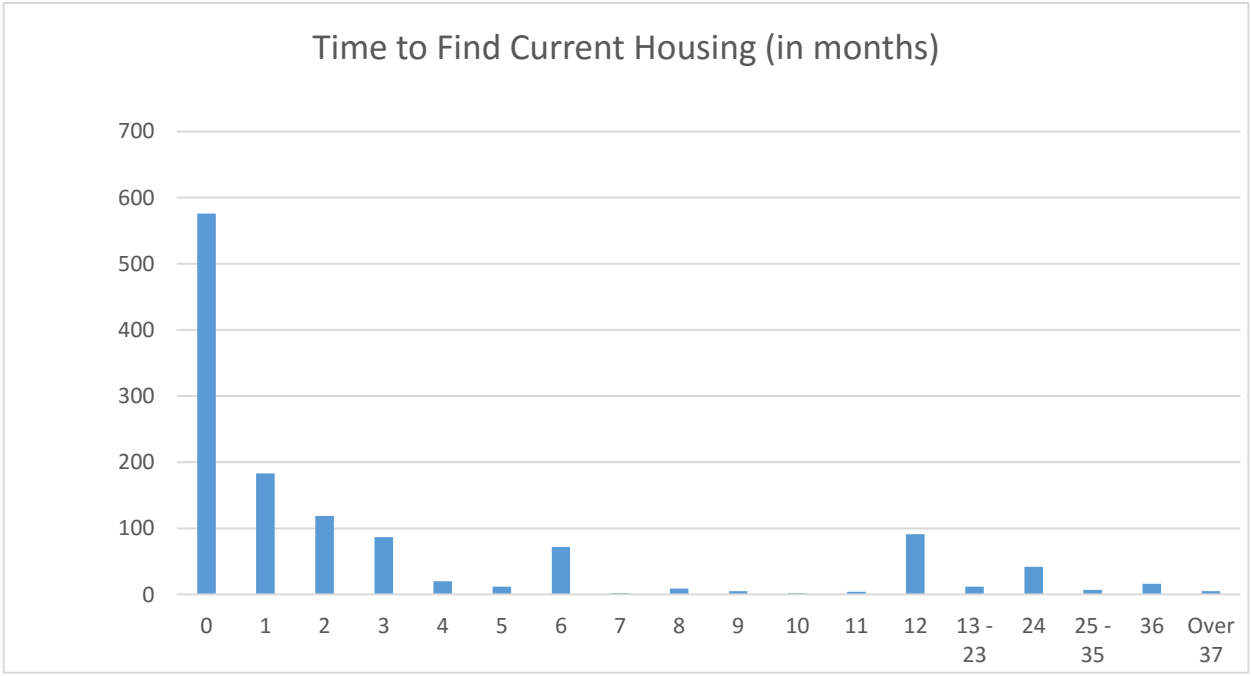
Q3: How long did it take you to find your current housing?

Time in Months	Count
0	576
1	183
2	119
3	87
4	20
5	12
6	72
7	2
8	9
9	5
10	2
11	4
12	91
13 - 23	12
24	42
25 - 35	7
36	16
Over 37	5
Don't Know	49
No Response	304

Participants that gave an answer of less than one month were counted in the "0" category. Examples include: "Not long", "a couple of days", "2 weeks".

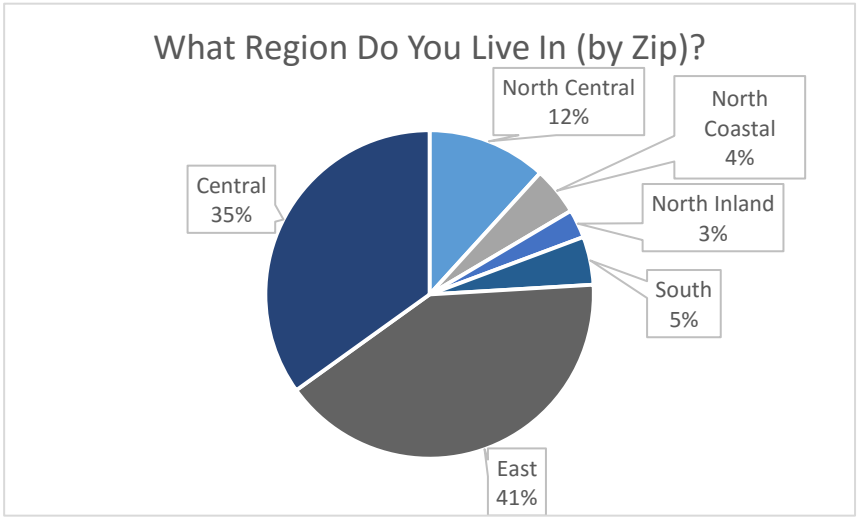
Participants that gave answers such as "I've always lived here" were counted in "No Response".

% of respondents that needed more than 6 months to find housing	21%
% of respondents that needed more than 1 year to find housing	14%
% of respondents that needed more than 2 years to find housing	6%
% of respondents that chose not to answer	19%
Percentages calculated based on respondents that knew how long it had been/chose to answer	



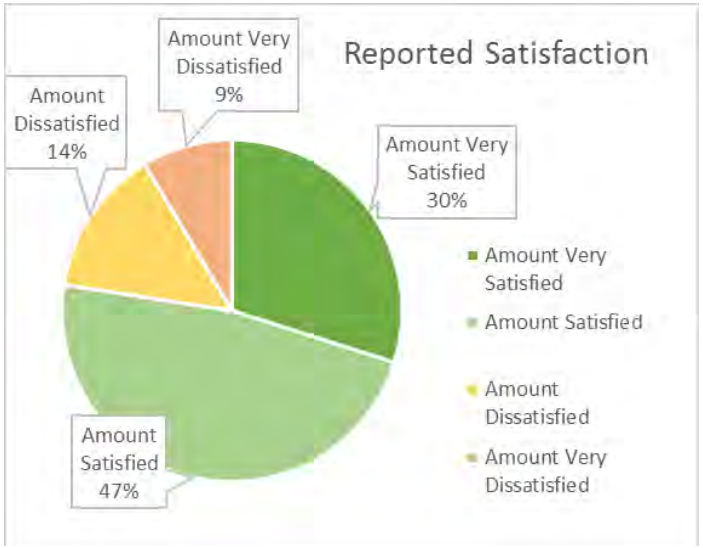
Q4: What zip code do you currently reside in?

North Central	171
North Coastal	69
North Inland	41
South	69
East	597
Central	508
Non-County/No Answer	163



Q5. How satisfied are you with your current housing situation?

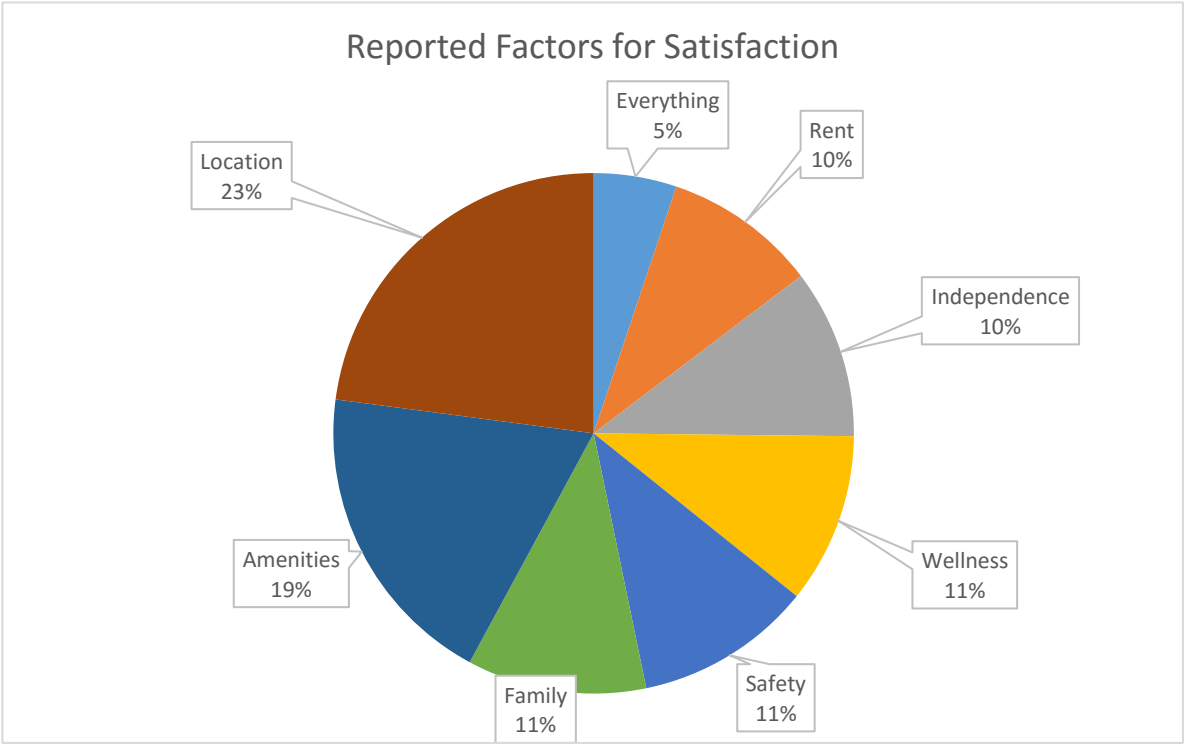
Amount Very Satisfied	473
Amount Satisfied	752
Amount Dissatisfied	221
Amount Very Dissatisfie	136
No Response	35



Q6. What do you like about your current housing?

Category	Count
Everything	73
Rent	135
Independence	149
Wellness	150
Safety	156
Family	158
Amenities	272
Location	325
No Response	199

Rent includes financial stability
Amenities includes walls/roof, wi-fi, food, pool, etc
Location includes social aspects of neighborhoods
Wellness includes treatment, counseling, staff, sober living



Q7. If you are not satisfied, why not?

Category	Count
Location	43
Homeless	50
Space Issue	54
Rent/Financial Hardship	93
Safety Problem	93
Social Friction	102
Lack of Independence	132
No Response	1050

% of respondents who are currently or will soon be homeless:	9%
% of respondents that indicated financial hardship:	16%
Percentages do not include nonresponse	

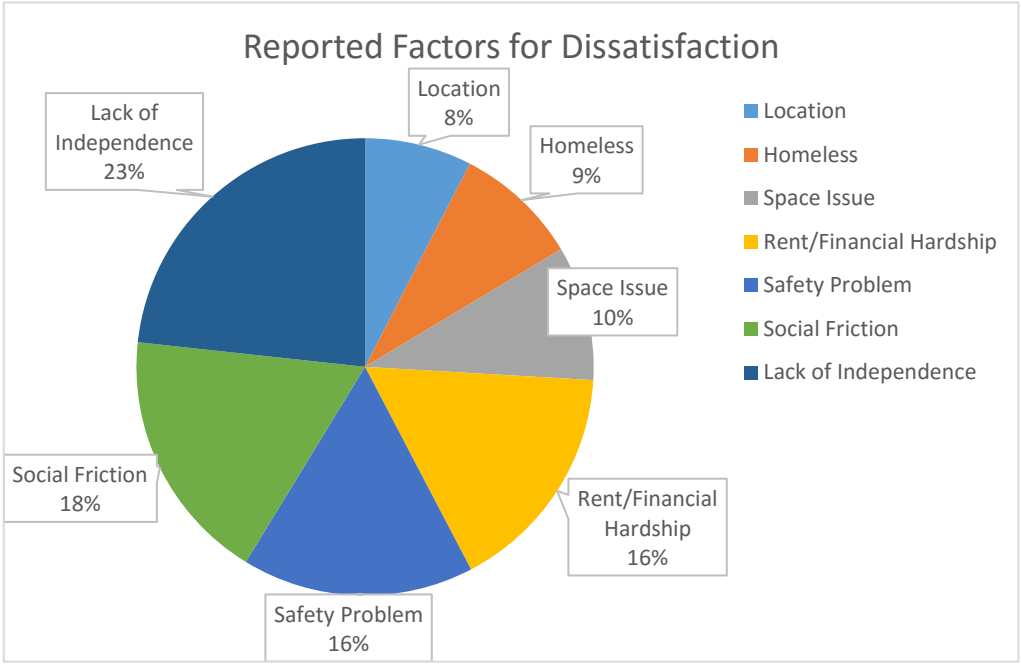
Rent/Financial Hardship includes rent, utilities, voucher

Lack of Independence includes wanting a place of one's own, restrictive staff, rules at facilities

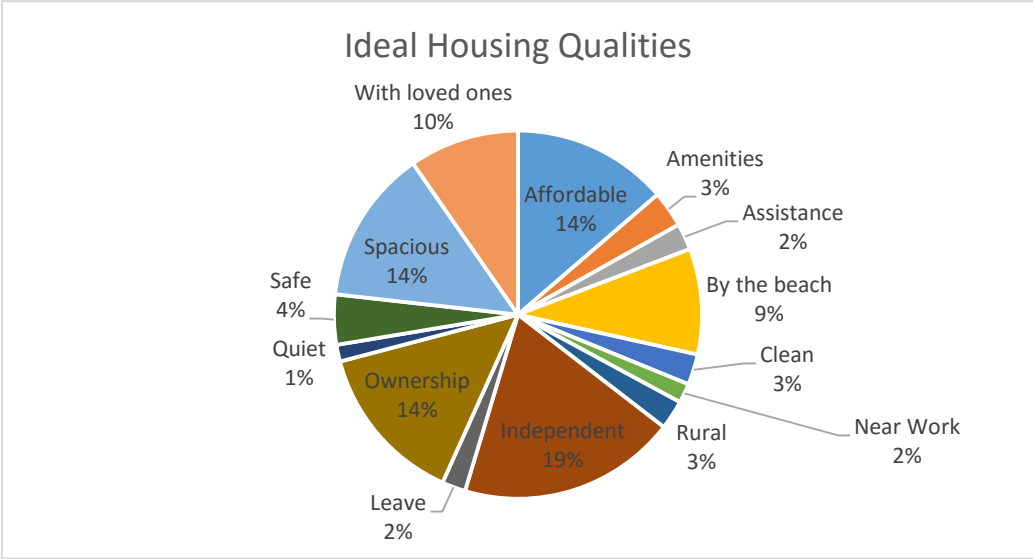
Social Friction includes roommate or family issues, neighborhood noise

Safety Problem includes infestations, cleanliness, needed repairs, neighborhood crime

Homeless includes temporary housing



Q8. What would your ideal housing be?



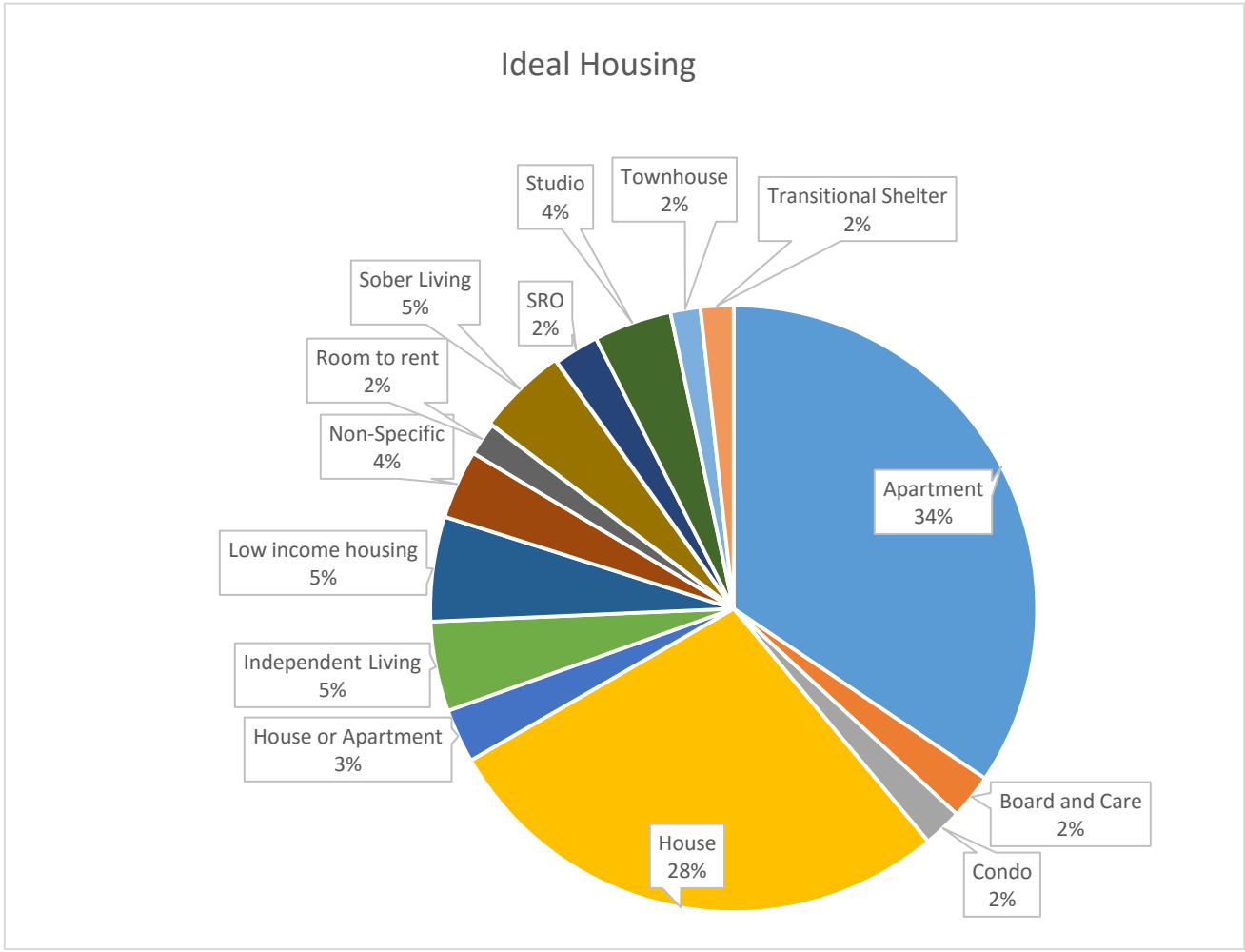
Consideration	Count
Affordable	112
Amenities	26
Assistance	19
By the beach	76
Clean	22
Near Work	14
Rural	21
Independent	157
Leave	17
Ownership	116
Quiet	12
Safe	36
Spacious	111
With loved ones	79

The most common ideal housing quality is "independent" which falls under the sentiment of "having a place of my own" or more privacy. This is different from the category of "ownership", which is when a respondent specifically states their desire to own their own home. Many respondants were not very particular about where they lived as long as they could afford it. "With loved ones" signifies when a respondant expresses a desire to live with either children or a significant other

Any answer that was not an ideal quality but rather a type of housing (such as apartment, house, etc) was omitted to prevent redundant data with question 9.

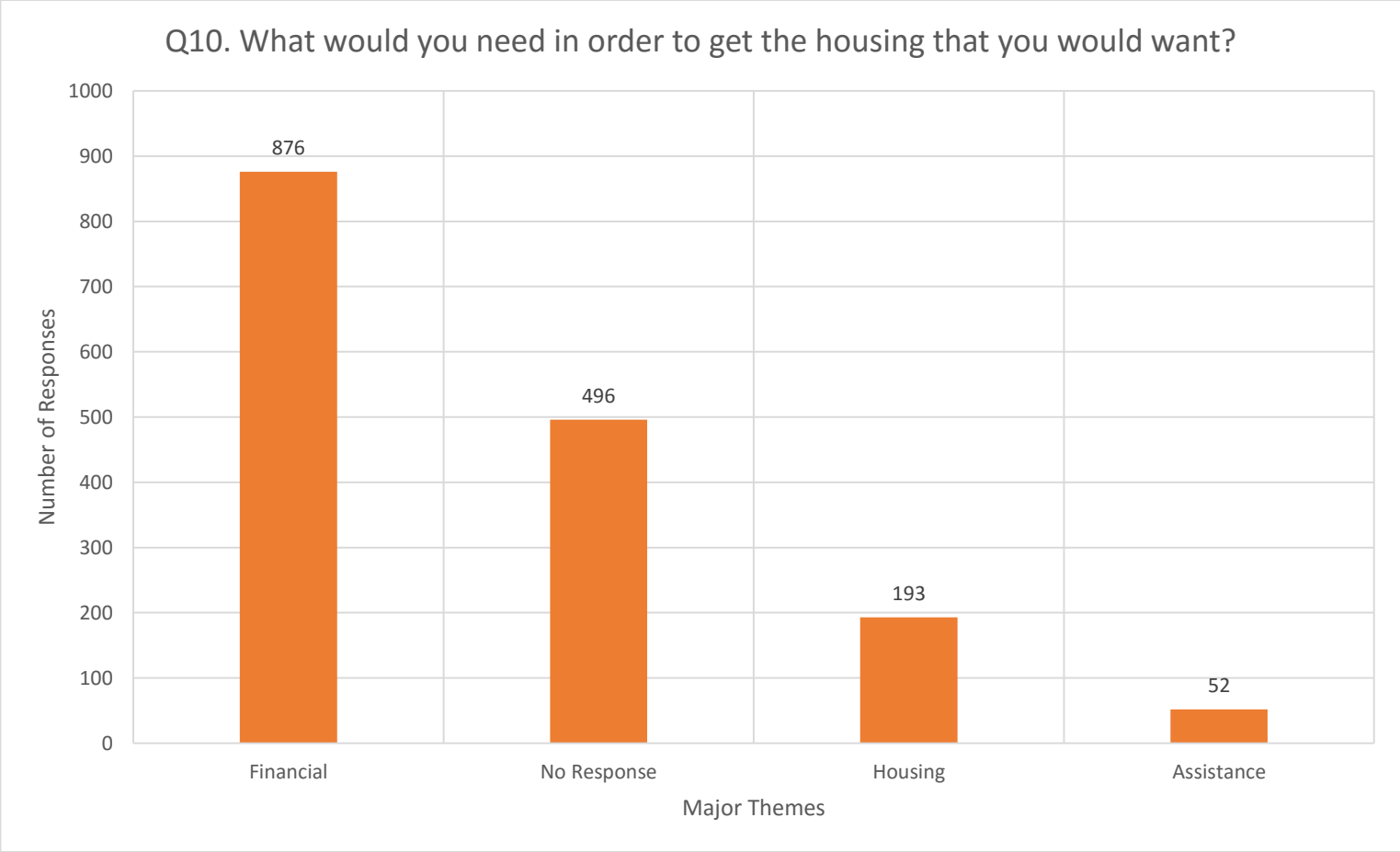
Q9: What type of housing are you looking for?

Category	Count
Apartment	216
Board and Care	15
Condo	13
House	174
House or Apartment	18
Independent Living	30
Low income housing	35
Non-Specific	23
Room to rent	11
Sober Living	30
SRO	15
Studio	26
Townhouse	10
Transitional Shelter	11
Non-Answer	990



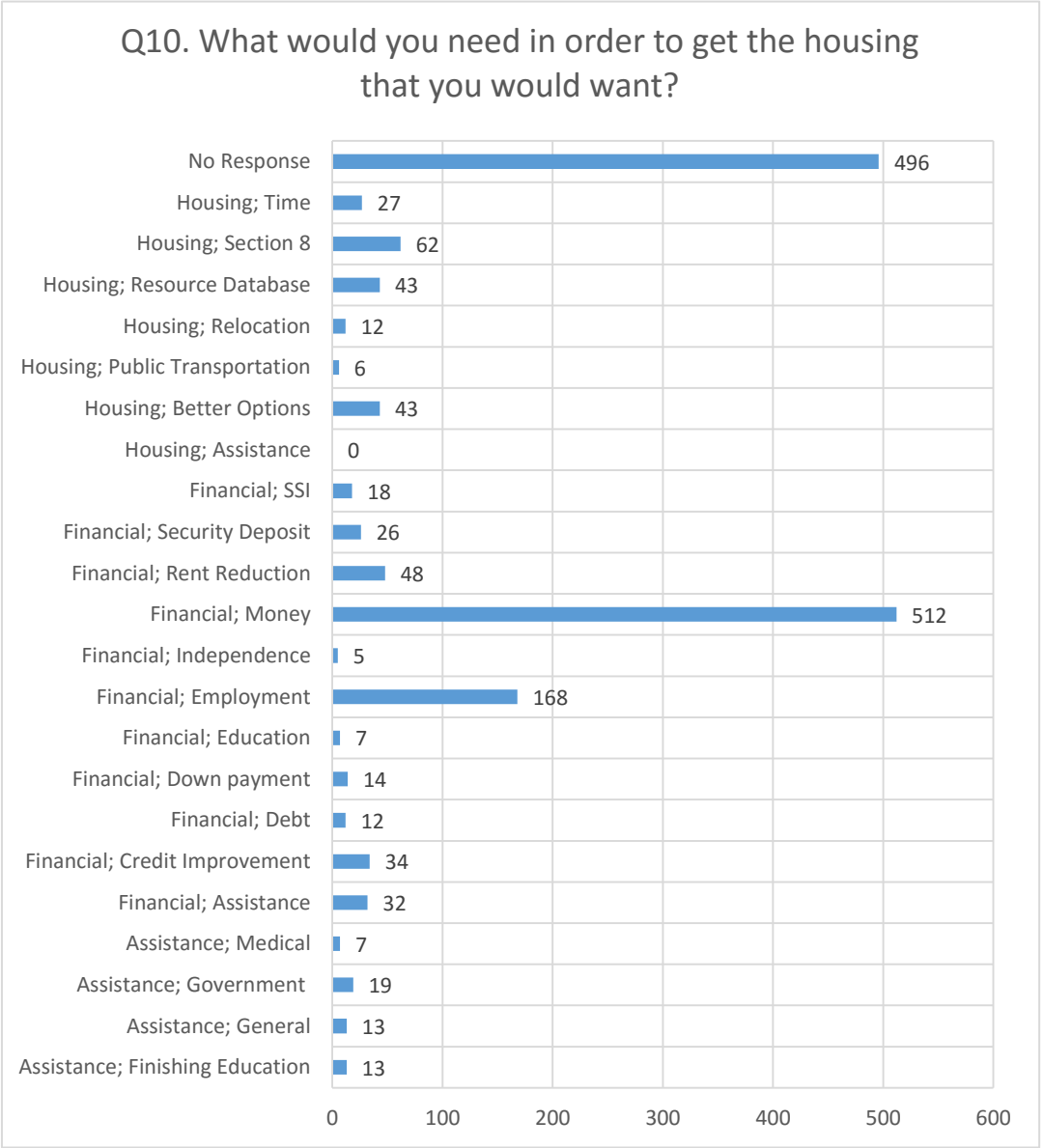
Q10. What would you need in order to get the housing that you would want?

Emerging Theme	# of Responses	% of Responses
Financial	876	54.17%
No Response	496	30.67%
Housing	193	11.94%
Assistance	52	3.22%



Q10. What would you need in order to get the housing that you would want?

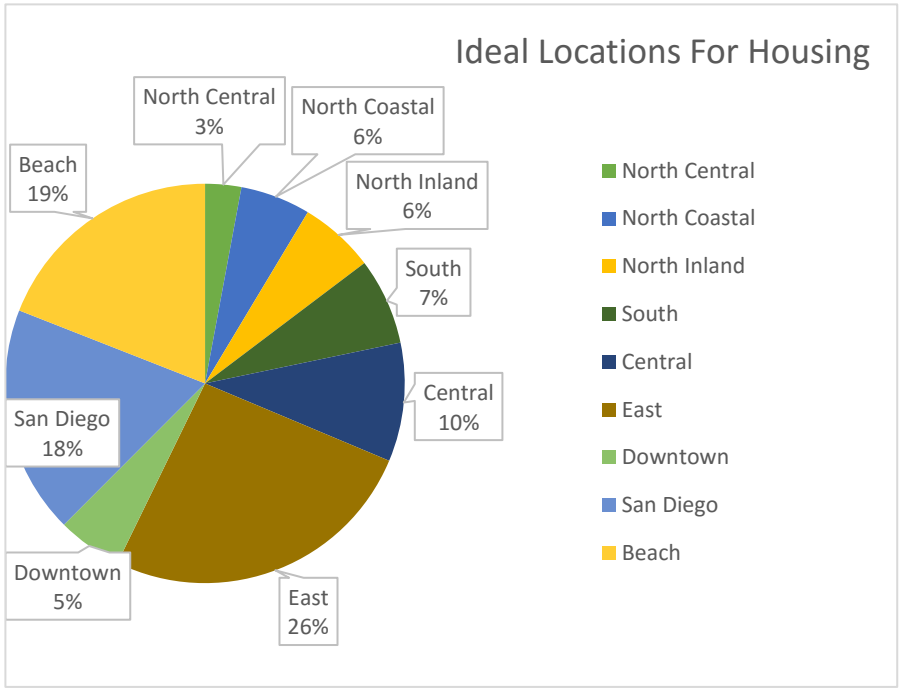
Column1	Column2
Assistance; Finishing Education	13
Assistance; General	13
Assistance; Government	19
Assistance; Medical	7
Financial; Assistance	32
Financial; Credit Improvement	34
Financial; Debt	12
Financial; Down payment	14
Financial; Education	7
Financial; Employment	168
Financial; Independence	5
Financial; Money	512
Financial; Rent Reduction	48
Financial; Security Deposit	26
Financial; SSI	18
Housing; Assistance	0
Housing; Better Options	43
Housing; Public Transportation	6
Housing; Relocation	12
Housing; Resource Database	43
Housing; Section 8	62
Housing; Time	27
No Response	496



Q11. Where in the City or County would your ideal housing be located?

	Region	Count
*The blue regions are not HHSA regions of San Diego, but are statistically significant responses not counted in HHSA Region Counts because they were too vague.	North Central	35
	North Coastal	68
	North Inland	73
	South	84
	Central	115
	East	310
	Downtown	63
	San Diego	221
	Beach	228

	Other Considerations	Count
*Responses here were given instead of locations, including "anywhere with a bus stop," etc	Leave County	38
	Safety	9
	Financial	15
	Rural	17
	Transit	12
	Mountains/Desert	7



% of respondents that chose not to answer or gave non-City/County answers	26%	
% of respondents that would rather leave San Diego County	2%	*Calculations done based on respondents that answered, omitting nonresponse
% of respondents that want to live by the beach	14%	
# of respondents that make housing decisions based on financial reasons	15	*Voluntary, unprompted addition to open-ended question
# of respondents that make housing decisions based on transit accessibility	12	

Q12. What amount in dollars can you realistically afford to pay? Approximately what percentage of your income is that?

Did Not Understand = Respondents gave an answer unrelated to question or answered "?"	Don't Know = Respondent indicated "Unknown", "Not sure", or "I don't know"	Choose Not to Answer = Respondent left blank or indicated refusal to answer, includes N/A

Percent (Approx)	Count
0	60
10	5
15	10
20	27
25	63
30	152
33.3	43
35	22
40	71
45	17
50	145
55	4
60	34
65	7
70	20
75	32
80	24
85	7
90	19
95	6
100	34
Choose Not to Answer	749
Did Not Understand	51
Don't Know	14

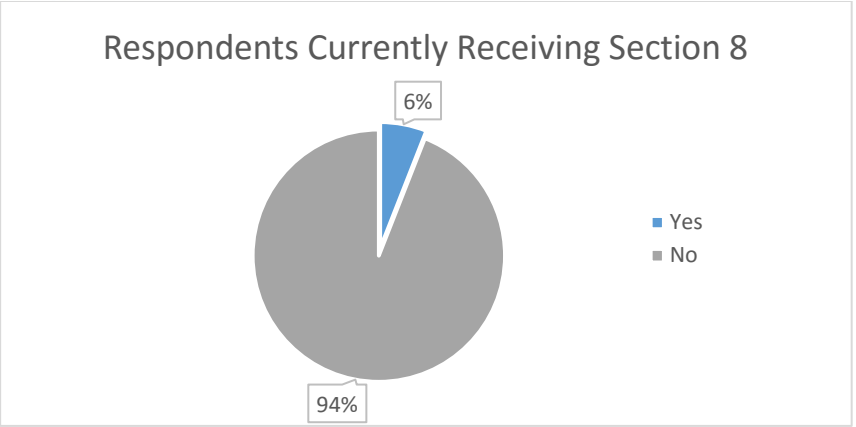
Amount in $	Count
Under 100	128
101-500	313
501 - 1000	438
1001 - 1500	169
1501 - 2000	64
2001 - 2500	19
2501 - 3000	18
3001 - 5000	5
5001 - 9999	3
Over 10000	10
Don't Know	20
Choose Not to Answer	410
Didn't Understand	19

All percentages calculated based on respondents that provided answers - nonanswers not included	
% of answering respondents paying over $500	62%
% of answering respondents paying over $1000	25%
% of answering respondents paying over $1500	10%
% of answering respondents that answered 0 (could not afford to pay anything/no income)	10%
% of total respondents that did not answer/did not understand $	28%

% of answering respondents paying 30% or more of their	79%
% of answering respondents paying 50% or more of their	41%
% of answering respondents paying 60% or more of their	23%
% of total respondents that did not answer/did not understand %	50%

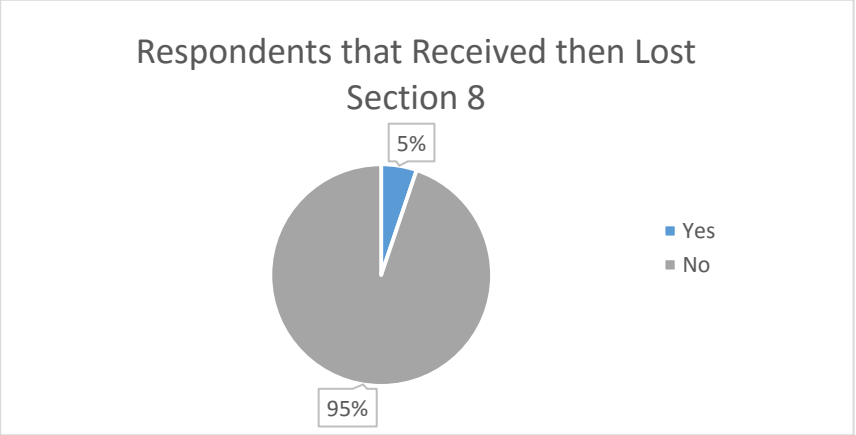
Q13. Are you currently receiving Section 8?

Yes	94
No	1484
No Response	39



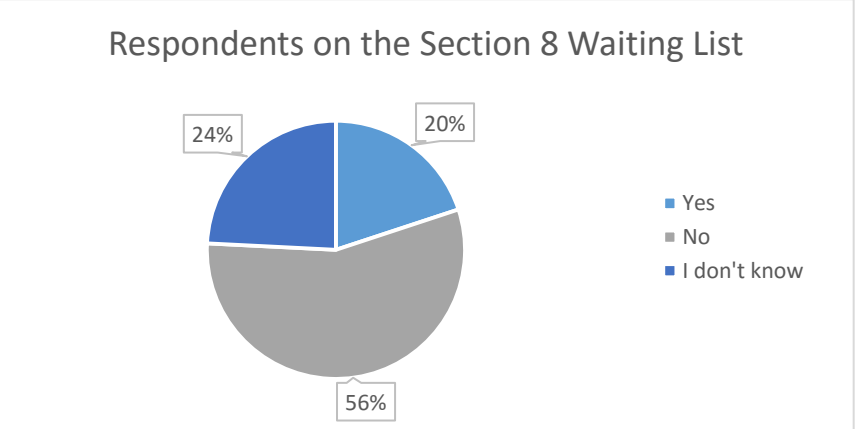
Q14. Have you ever received and lost Section 8?

Yes	81
No	1481
No Response	55



Q15. Are you on the Section 8 waiting list?

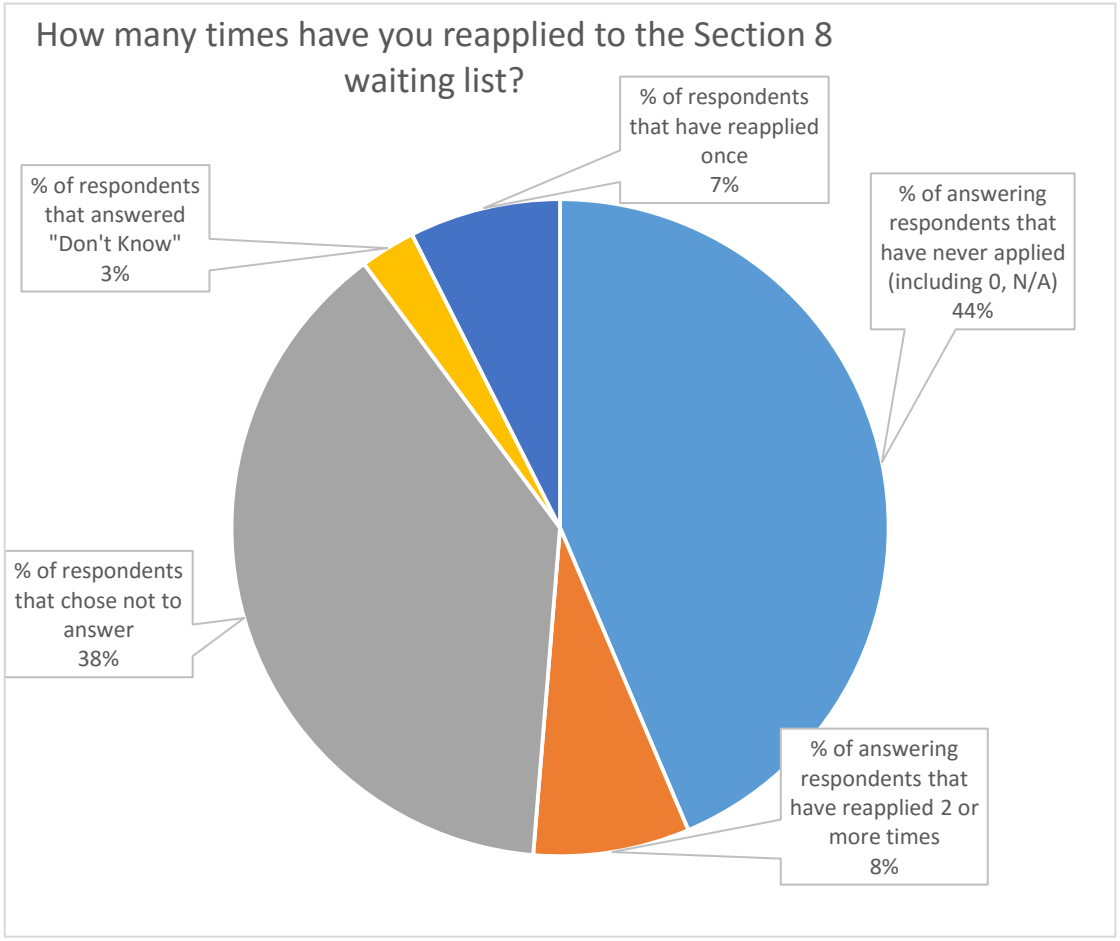
Yes	313
No	877
I don't know	380
No Response	47



Q16. How many times have you reapplied to the Section 8 waiting list?

Response	Count
12	2
10	7
9	2
8	3
6	4
5	11
4	5
3	23
2	67
1	120
0	703
Don't Know	44
No Response	621

% of answering respondents that have never applied (including 0, N/A)	43.61%
% of answering respondents that have reapplied 2 or more times	7.69%
% of respondents that chose not to answer	38.52%
% of respondents that answered "Don't Know"	2.73%
% of respondents that have reapplied once	7.44%



Q17. Do you find it difficult to keep your information current on the Section 8 waiting list?

Yes	223
No	528
I don't know	548
No Response	318

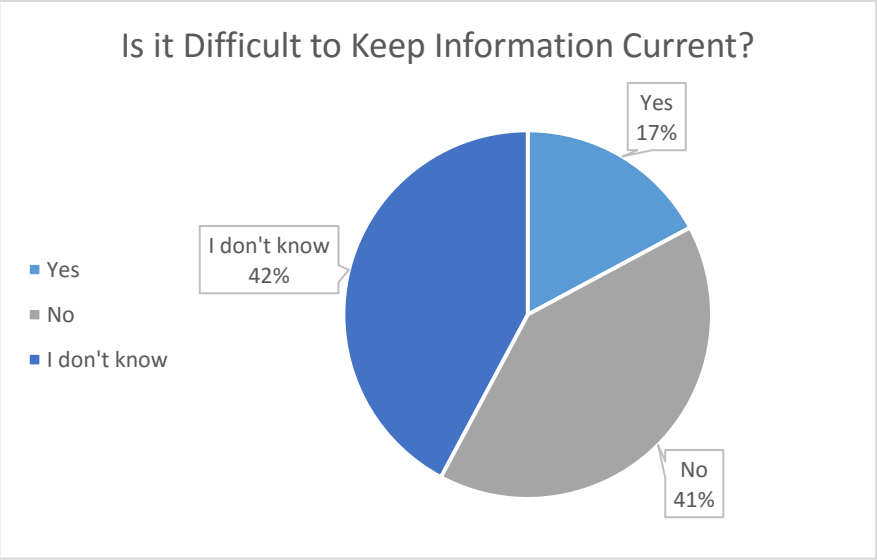
→

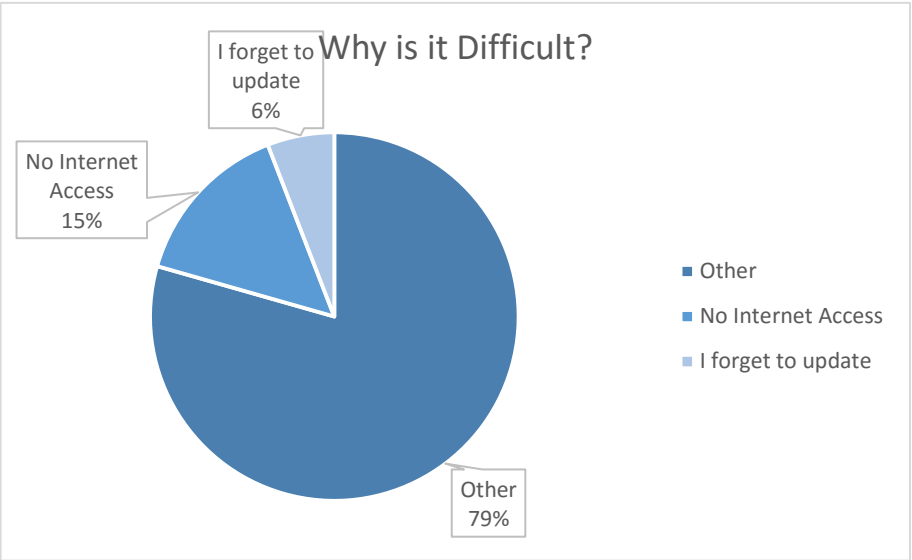
Other	162
No Internet Access	30
I forget to update	12
No response	324

→ "Other" answer include "I didn't apply", "I make too much", and other redundant data.

Valuable insights from "Other" answers:

Difficult to prove respondents called to update information, long wait times on the phone, confusing forms, they didn't know they needed to update their info, and no warning when a respondent is coming up on time to update.

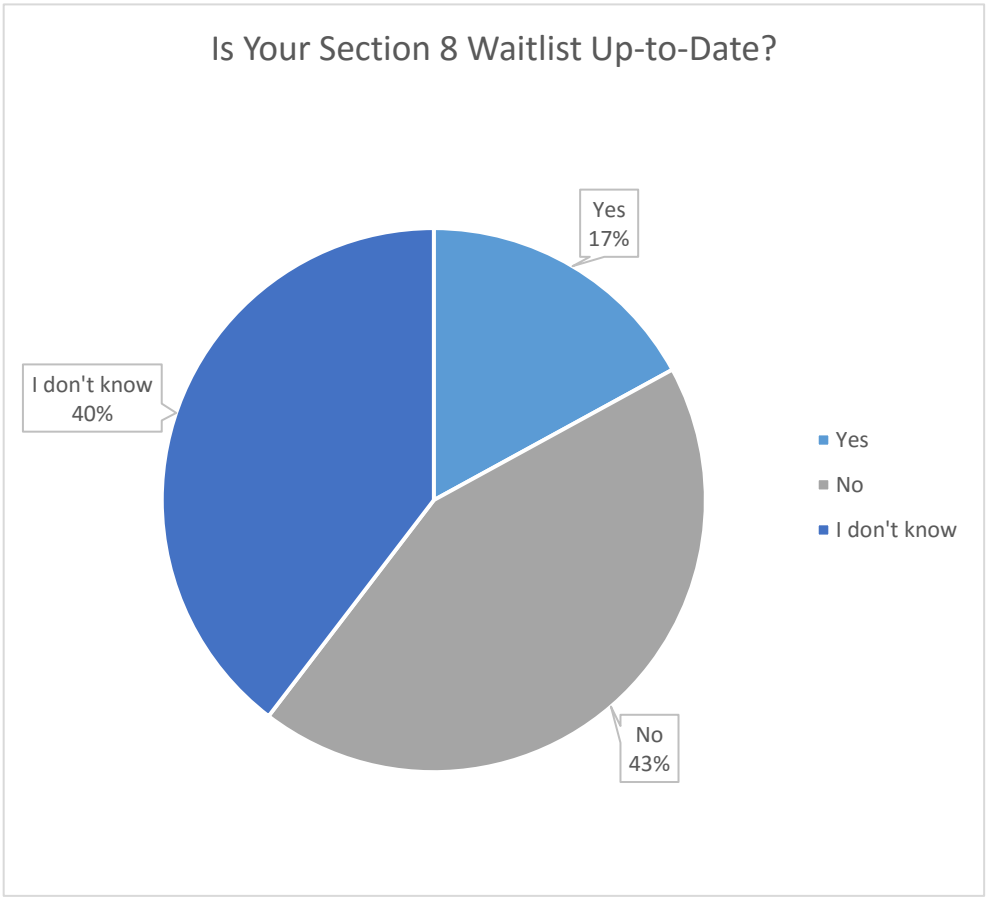




This question was by far the most confusing for respondents. The survey asks "Do you find it difficult to keep your information current on the Section 8 waiting list?" then "If No, why is your information not currnet?" The second part of the question is a non-sequetor and assumes the respondant's information is not current.

Q18. If you are on the Section 8 waitlist, is your Section 8 application currently up to date?

Yes	200
No	509
I don't know	465
No Response	443



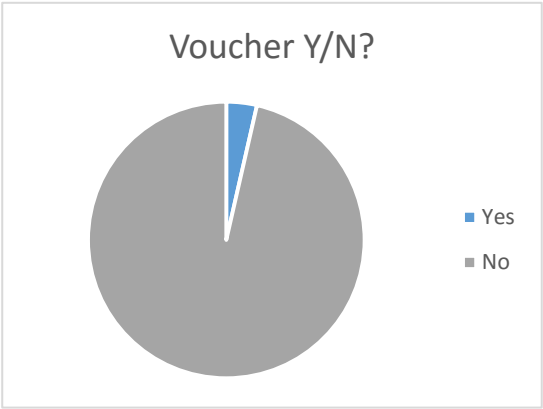
Q19. Do you currently have a Section 8 voucher, but are unable to find a unit?
If yes, how long have you been looking for a unit?

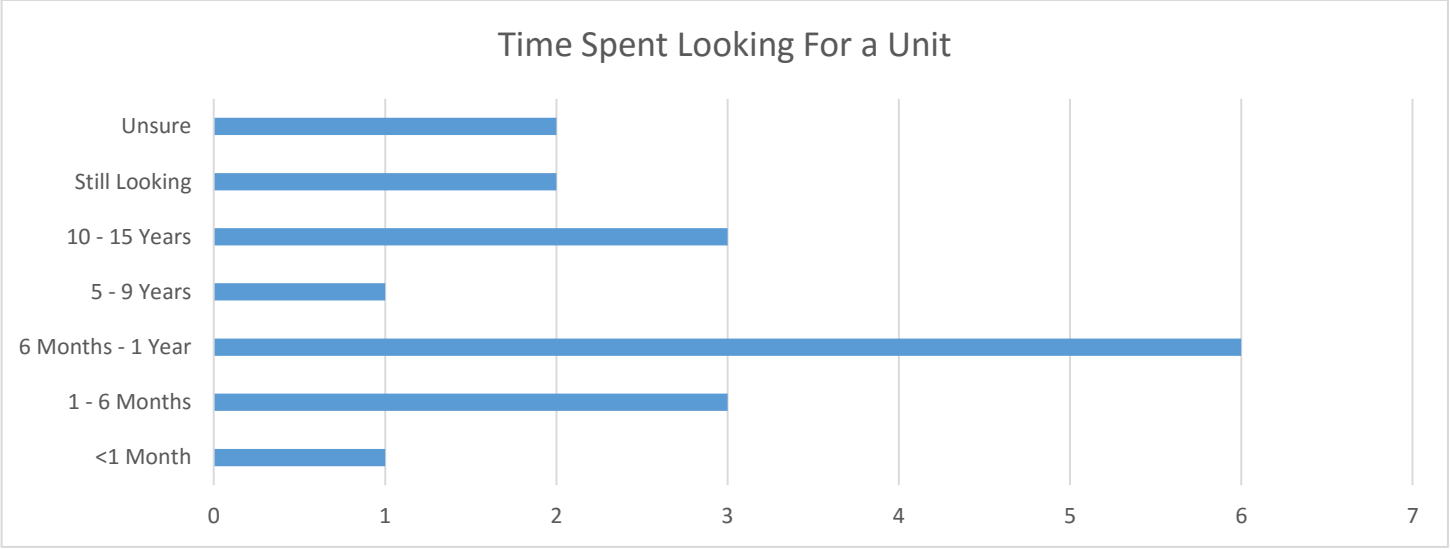
Yes	48
No	1296
No Response	273

Of the responses the open-ended field yielded responses with no relation to question	
No Correlation	4
N/A	9
Conflict	3

→

Duration	Quantity
<1 Month	1
1 - 6 Months	3
6 Months - 1 Year	6
5 - 9 Years	1
10 - 15 Years	3
Still Looking	2
Unsure	2

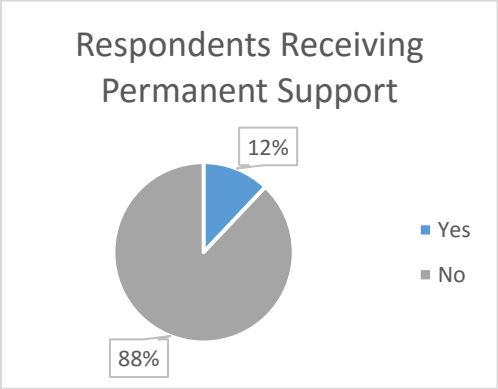




Q20. Are you receiving any permanent housing rental support?

If yes, what kind of rental support?

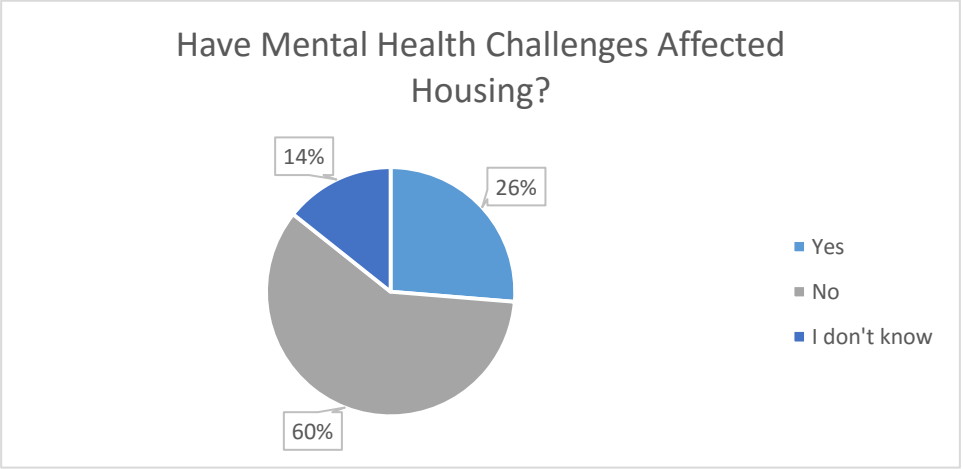
Yes	179
No	1307
No Response	131



Category of Support	Count
Family/Roommate	21
SSI/SSA	21
HUD/HUD VASH	11
Telecare	10
Section 8	9
Downtown Impact Voucher	5
Low-Income/Rent Controlled Housing	3
Project 25	3
Unspecified funds ("Program funds")	3
AB109	2
Case Management	2
Chula Vista South Bay Community Servic	2
Path Connections	2
SAT Voucher	2
Catalyst	1
Center Star ACT	1
EBT	1
Father Joe	1
Interfaith	1
Medical VA	1
Medication Management	1
PARS	1
Rental Assistance SBV	1
Residential Rehab	1
SDYS	1
Shelter Plus Care Program	1
SNAP	1
Sober Living	1
Sponsor-based Subsidy	1
TACHS	1
VASA	1
VVSD	1

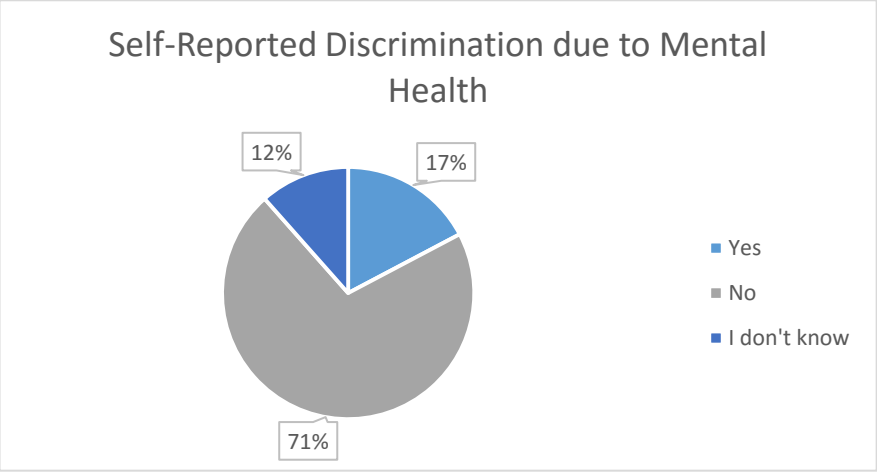
Q21. Do you believe your mental health challenges have affected your housing?

Yes	397
No	897
I don't know	216
No Response	107



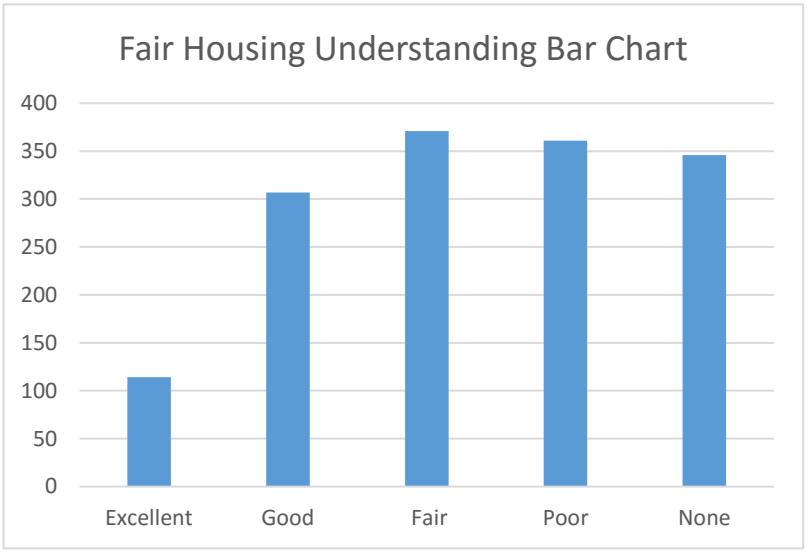
Q22. Have you felt discriminated against because of your mental health challenges?

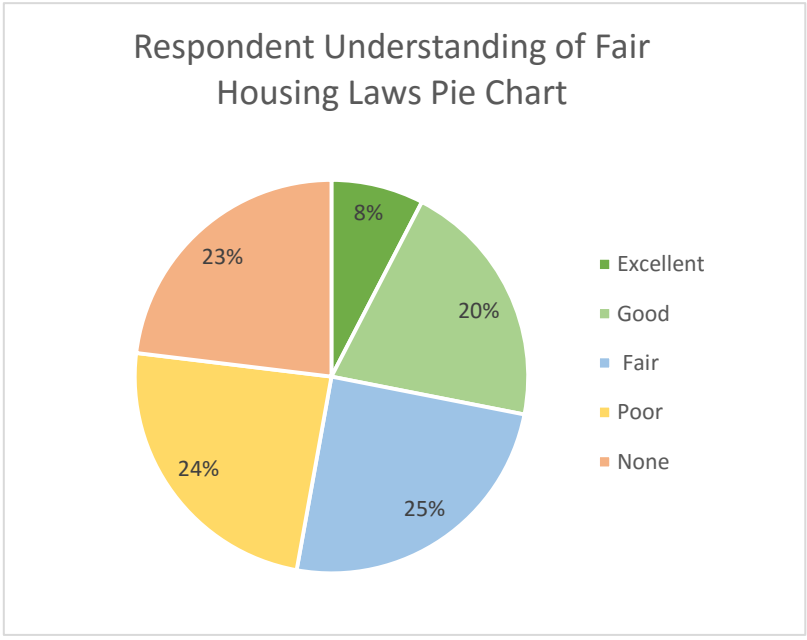
Yes	256
No	1055
I don't know	171
No Response	135



Q23. How would you rate your understanding of Fair Housing laws?

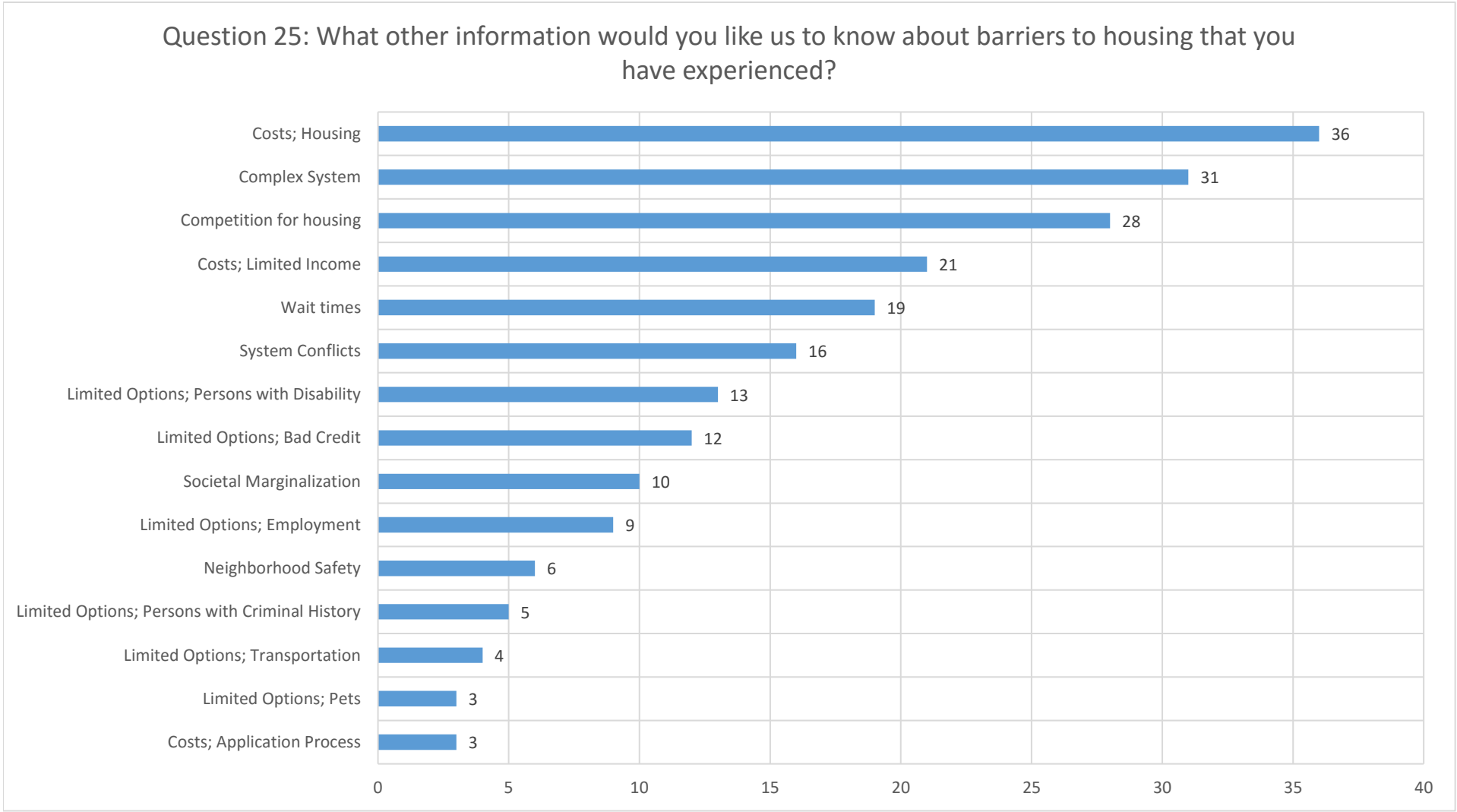
Excellent	114
Good	307
Fair	371
Poor	361
None	346
No Response	118





Q24. What obstacles have you encountered in your search for housing or better housing? (select all that apply):

Not enough income for current rent	853	53%
Not enough income to cover 1st month and security deposit	669	41%
Not enough income to cover security deposit	523	32%
Not enough income to live in a neighborhood I would want to be in	605	37%
Not enough income to live in a neighborhood I would feel safe in	514	32%
Not enough income to live in a neighborhood that is easily accessible by public transportation	284	18%
Problems with credit check	458	28%
Problems in rental history (evictions or late rent payments)	189	12%
Problems with past criminal history	198	12%
Problems finding housing where I can have my pet	236	15%
Problems finding housing where I can have my children	90	6%
Problems finding housing where I can live with my partner	76	5%
Not enough money to buy food, if I pay rent	468	29%
Not enough money to get my prescriptions, if I pay rent	191	12%
I have a rental voucher, but I don't understand how it works	39	2%
Discrimination due to mental health challenges	94	6%
Other, described in Q25	180	11%



These are the emerged from the open-ended question 25.

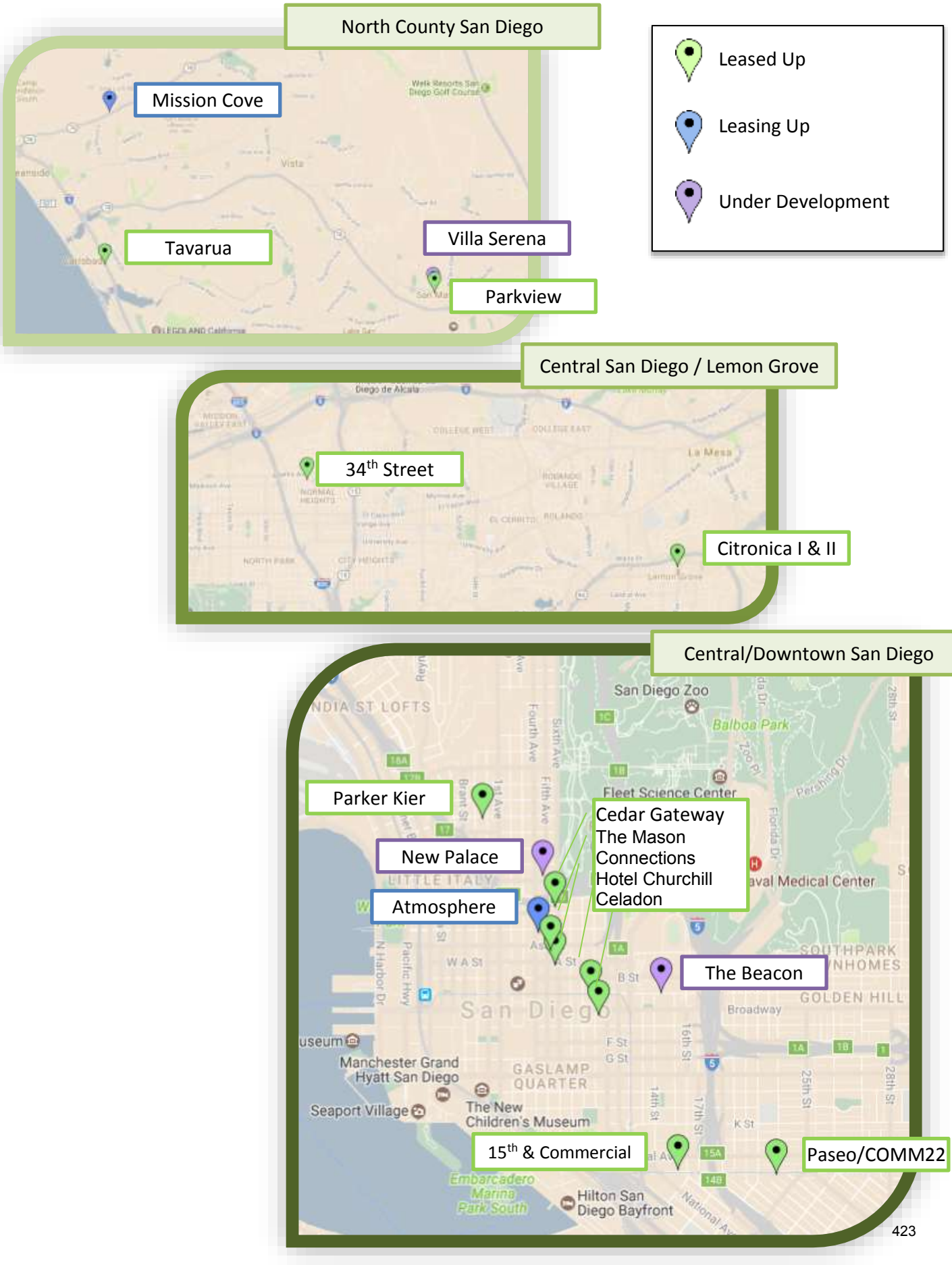
E. MHSA Housing Pipeline Chart

Name	MHSA Units	Total Units	Expected Opening	New or Acq/ Rehab	Location	Target Pop	FSP	Developer(s)	Comments
DEVELOPMENTS CURRENTLY OPERATING									
34th Street	5	34	2010	Acq/ Rehab	San Diego	Adults	CRF IMPACT	Townspeople	Lease-up completed April 1, 2011
15th & Commercial	25	65	2011	New	San Diego	OA/ Justice	CRF Senior IMPACT /MHS C. Star	Father Joe's Villages	Lease-up began Dec 15, 2011
Cedar Gateway	23	65	2012	New	San Diego	Adults/ OA	CRF Sr. IMPACT/IMPACT	Squier/ROEM	Lease-up began March 1, 2012; Grand opening March 21, 2012
The Mason	16	16	2012	Acq/ Rehab	San Diego	Adults	CRF IMPACT	HDP	Lease up began October 2012; Grand opening February 2013
Connections Housing	7	73	2013	Acq/ Rehab	San Diego	Justice	MHS C. Star	Affirmed/PATH	Opened in February 2013; Grand Opening March 11, 2013
Tavarua Senior Apts.	10	50	2013	New	Carlsbad	OA	CRF Senior IMPACT	Meta Housing	Lease-up/occupancy in April 2013
Citronica One	15	56	2013	New	Lemon Grove	TAY	Pathways Catalyst	Hitzke Development	Grand Opening September 2013
Citronica Two	10	80	2014	New	Lemon Grove	OA	CRF Senior IMPACT	Hitzke Development	Leased up in September 2014
Paseo (COMM 22)	13	130	2014	New	San Diego	TAY	Pathways Catalyst	BRIDGE/MAAC	Leased up September 2015; Grand Opening May 8, 2015
Celadon (9th & Broadway)	25	250	2015	New	San Diego	TAY/Adults	Pathways Catalyst/ CRF IMPACT	BRIDGE	Leased up in December 2015
Parker-Kier	22	34	2013	Acq/ Rehab	San Diego	Adults/ Justice	CRF IMPACT/MHS C. Star	HDP	Leased up in November 2013
Parkview	14	84	2014	New	San Marcos	Adults/ Justice	MHS N. Star/C. Star	Hitzke Development	Leased up, Grand Opening October 30, 2014
Churchill	16	72	2016	Acq/ Rehab	San Diego	TAY/ Justice	Pathways Catalyst/ MHS C. Star	HDP	Grand Opening September 2016; Leased up in December 2016
SUBTOTAL	*201*	*1009*							
DEVELOPMENTS UNDER CONSTRUCTION									
Atmosphere	31	205	2017	New	San Diego	Adults	CRF IMPACT	Wakeland	Ground breaking March 24, 2015; Lease up in March 2017
Mission Cove	9	90	2018	New	Oceanside	TAY	Pathways Catalyst/Vista TAY	National CORE	Ground breaking Aug 12, 2014; Lease up anticipated Jan 2018
SUBTOTAL	*40*	*295*							
GRAND TOTAL	**241**	**1304**							

LQ 3/13/2017

Name	MHSA Units	Total Units	Expected Opening	New or Acq/ Rehab	Location	Target Pop	FSP	Developer(s)	Comments
DEVELOPMENTS IN SNHP PIPELINE									
The Beacon Apartments	22	44	2019	New	San Diego	Adults	TBD	Wakeland	30-day posting on 1/13/2017
New Palace Hotel	10	79	2018	Acq/ Rehab	San Diego	OA	Telecare AgeWise	HDP	30-day posting on 1/13/2017

F. MHSA Housing Developments Maps



G. MHSA Special Needs Housing Program Guidelines and Recommendations

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY BEHAVIORAL HEALTH SERVICES ADULT/OLDER ADULT MENTAL HEALTH SERVICES

LOCAL GOVERNMENT SPECIAL NEEDS HOUSING PROGRAM (SNHP)

GUIDELINES FOR APPLICATION

FOR FUNDS TO ACQUIRE, CONSTRUCT, AND/OR REHABILITATE PERMANENT SUPPORTIVE HOUSING FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS

February 2017

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Background

In 2004, the people of the State of California passed Proposition 63, which established the Mental Health Services Act (MHSA) to create new funding for mental health services for unserved and underserved persons with serious mental illness. In 2007, the MHSA housing program was created as a limited-term program to administer MHSA funds set aside to finance permanent supportive housing for individuals with mental illness. The County of San Diego utilized the initial MHSA allocation to create 249 new housing opportunities for some of the most vulnerable clients in San Diego County. The MHSA Housing Program concluded on May 30, 2016, with the original $33 million in funding expended or committed to San Diego projects.

However, as homelessness for individuals with serious mental illness continues to be a priority for the County of San Diego, Behavioral Health Services has decided to utilize the successor program to the MHSA Housing Program, the California Housing Finance Agency (CalHFA) Local Government Special Needs Housing Loan Program (SNHP), by committing $10,000,000 in funds for additional housing units to support a healthy, safe and thriving community.

The commitment of these funds support the Healthy Families initiative of the County of San Diego's 2015-2020 Strategic Plan as well as the *Live Well San Diego* vision by providing necessary resources and services for individuals with behavioral health needs to lead healthy and productive lives. Additional permanent supportive housing units are expected to promote a safe and thriving community while addressing the priority issue of serving individuals who are both homeless and have a serious mental illness.

In order to submit an application for funding to the State, the sponsor must first go through a review process with the County of San Diego Behavioral Health Services (SDBHS). SDBHS will review projects that meet the County goals to serve individuals who are both homeless and have a serious mental illness as well and the County's priority criteria. By recommending a project for funding, SDBHS will commit to providing the appropriate supportive services. These guidelines describe the process for local review prior to submitting the application to CalHFA for final funding approval and underwriting.

Program Recommendations and Guidelines

The County will review proposals for the construction or acquisition and renovation of either rental units or shared units using SNHP Funds.

Developers applying for funding under the SNHP program should consult with the County of San Diego Behavioral Health Services department to identify the appropriate population for the project prior to application to CalHFA. Priority populations for the SNHP program are people with serious mental illness (SMI) who are unserved or underserved including, Transition Aged Youth (TAY), Adults, Older Adults, and those involved in the justice system. The housing units that are created will be primarily dedicated to individuals eligible for MHSA-funded Full Service Partnership (FSP)

programs that provide wraparound services to individuals with serious mental illness who also have unmet housing needs.

PRIORITY CRITERIA

SNHP Funds are prioritized for projects that:

- Meet the goals of the BHS Strategic Housing Plan (http://sandiego.camhsa.org/housing.aspx)
- Meet CalHFA SNHP criteria http://www.calhfa.ca.gov/multifamily/snhp/application/index.htm
- Meet the *MHSA Housing Program Recommendations and Guidelines* (Attachment Two)
- Have operating subsidy funding commitments that ensure SNHP units are affordable to tenants with SSI (or who have SSI level incomes), or have sufficient cash-flow to operate without operating subsidy commitments
- Demonstrate project readiness (e.g. site control; entitlements; permits; funding commitments or active pursuit of funding commitments; etc.)
- Demonstrate a project timeline of planned start of construction within two years of SNHP Application submission to County BHS
    - Due to the urgent need for housing, priority is given to projects that will have units available in a timely manner (e.g. will receive their Certificate of Occupancy in less than two years of an SNHP Application submission)
- Tenant population mix/priority populations (e.g. TAY, Adult, Older Adult, Justice System involved)
- Region
- Overall unit mix of the development, including unit size (see Attachment Two for project design element information)
- SNHP investment per unit

Project sponsors who are approved for SNHP funding must involve client representatives and family members in the design and planning process if they are proposing a new project that has not already been through the design process. SDBHS will assist the developer in organizing client representatives and family members to provide feedback, when necessary.

Capital funds may be used for either rental housing developments (5 or more units) or shared housing developments (1-4 units for MHSA eligible clients who rent a bedroom within a single family home, duplex or tri-plex or four-plex). However, all projects must reserve a minimum of 5 units (or 5 bedrooms in shared housing) for County referred MHSA eligible tenants.

The County intends to utilize the SNHP funding to finance capital development only. Applicants are encouraged to seek other rent or operating subsidies, such as Project Based Section 8 vouchers, to subsidize rent for the very low income clients expected to be served under the SNHP program. Maximum rents for SNHP funded units will be limited to 30% of 30% of AMI.

Projects submitted for approval are subject to loan limits on each unit, in accordance with the CalHFA SNHP Term Sheet (Attachment 3). However, the County reserves the right to

limit or expand the recommended loan limits to meet its current housing needs. In any instance, the minimum SNHP Loan amount per Project will be set at $500,000.

Application for SNHP Funding

To initiate the application process, the following documents should be completed and sent to SDBHS:

- The Development Summary Form (Attachment One)
- A maximum two-page narrative description of the proposed project and the experience of the sponsor in developing and operating affordable and supportive housing

This information can be submitted via email to Jason Miller at Jason.Miller@sdcounty.ca.gov (he is reachable by phone at 619-584-5086) and cc'd to Simonne Ruff at Simonne.Ruff@csh.org (or by phone at 619-232-3194 ext. 4292).

Once these documents are received, Mr. Miller will arrange a meeting between Dr. Garcia, Director of Adult Systems of Care for San Diego County Behavioral Health Services (SDBHS) and the applicant to discuss the funding request. The purpose of the meeting is for a preliminary project review to discuss the project concept and whether the proposal is consistent with the San Diego MHSA Housing Plan Recommendations and Guidelines (Attachment Two).

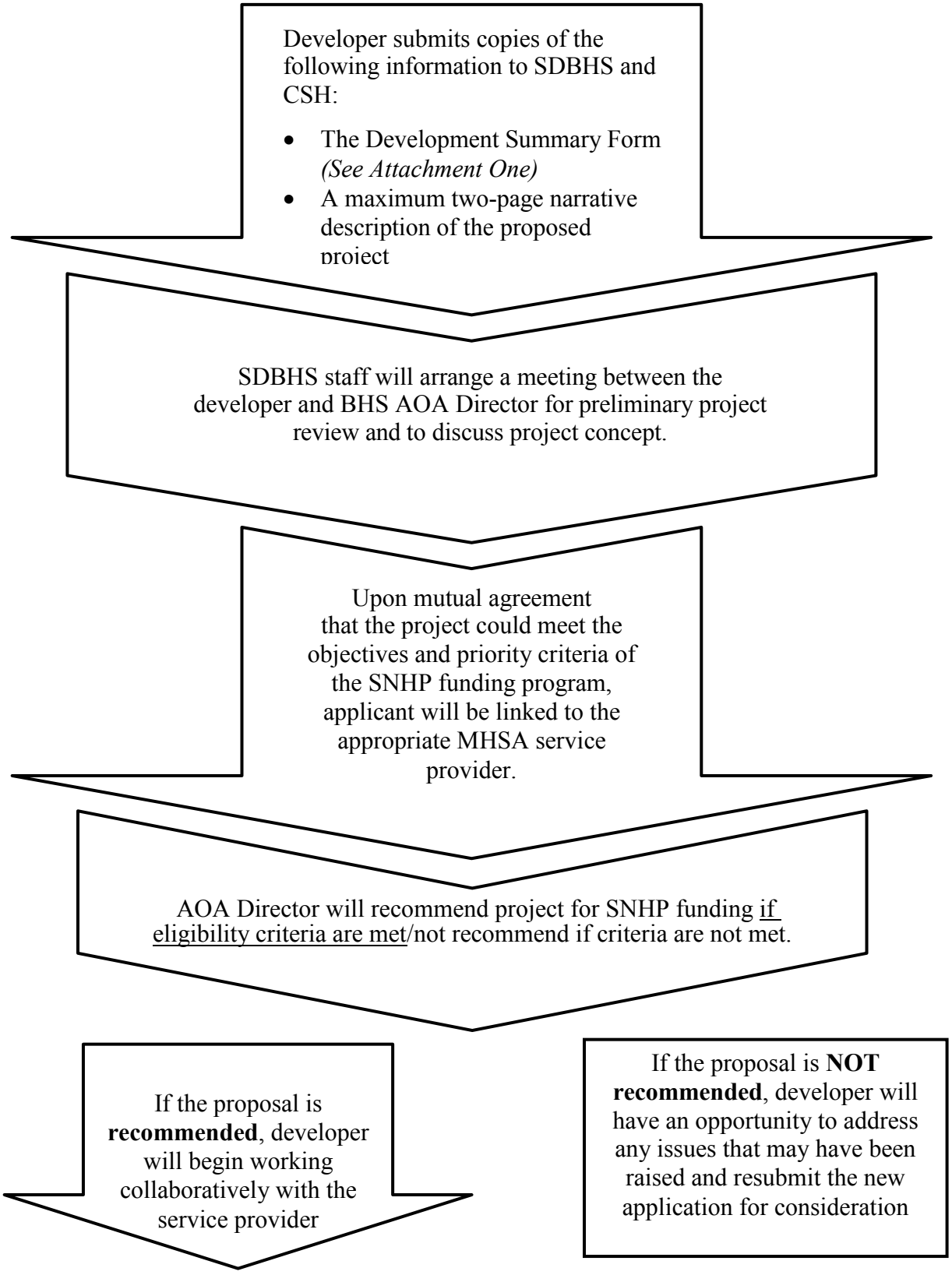
SELECTION PROCESS

Applications are received on an "over the counter" basis. The selection process is outlined in the flow chart below and includes an evaluation of the proposed project, including an assessment of whether a project meets the SNHP priority criteria (listed above). Following this review, BHS will determine whether a project will be recommended to CalHFA for underwriting and loan approval. If a project is recommended, then the applicant will complete the full application to be submitted to CalHFA for final funding approval. However, the application for SNHP funding may **only** be submitted by the County of San Diego Behavioral Health Services (SDBHS). Once an application has been approved at the State level by California Housing Finance Agency (CalHFA), the funds are distributed to a qualified borrower in the form of a loan administered by CalHFA. Therefore, the prepared application must be reviewed and signed by both SDBHS and the developer prior to submission to CalHFA.

By signing and submitting the application, the County Behavioral Health Services Director will signify that the SDBHS:

- Approves the use of a portion of its SNHP funds for the supportive housing project described in the application,
- Authorizes CalHFA to administer the SNHP loan,
- Commits to providing supportive services to the MHSA tenant population of the project for the full term of the SNHP loan.

SNHP: Housing Program Application Process Chart



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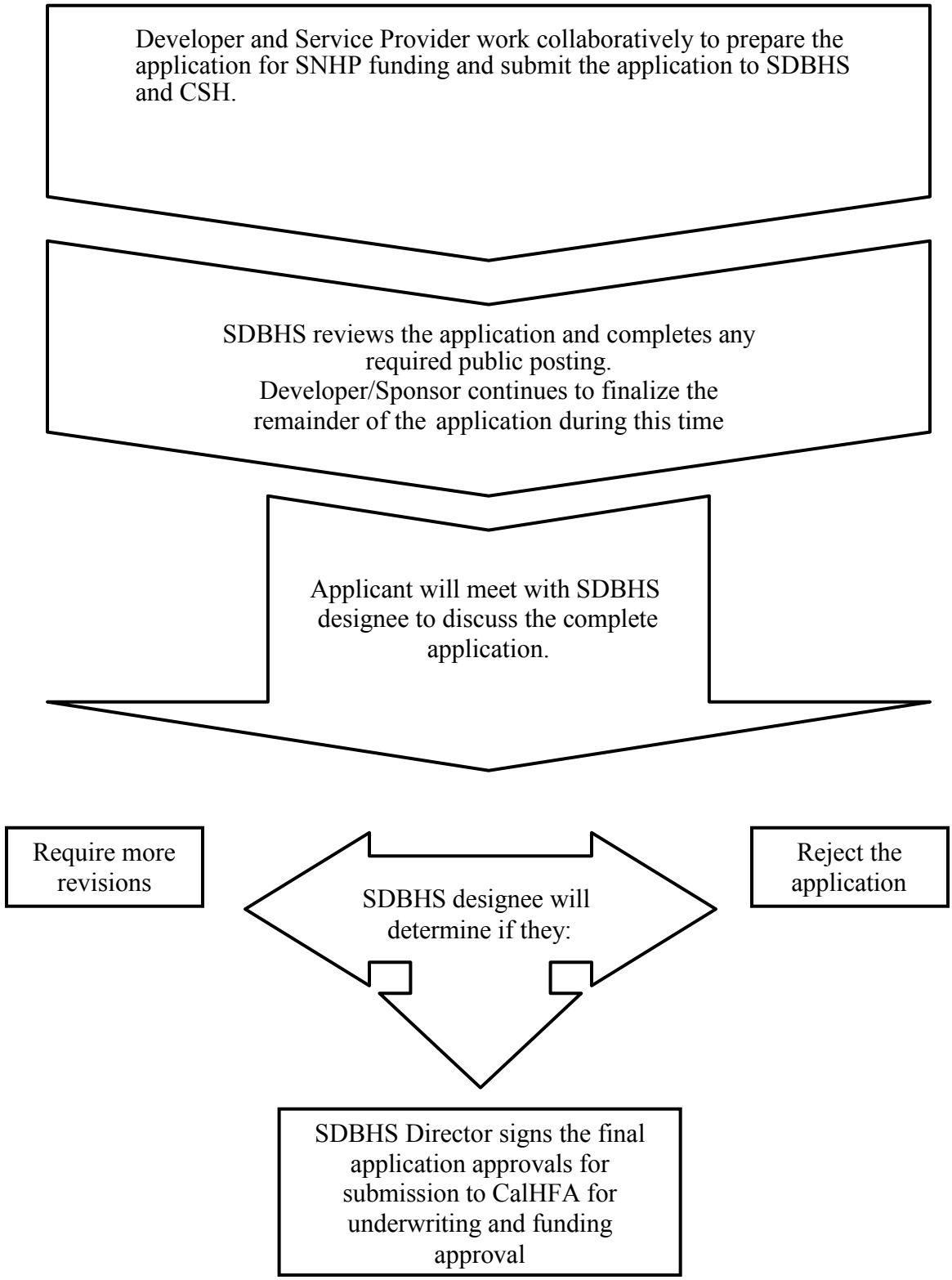

Developer and Service Provider work collaboratively to prepare the application for SNHP funding and submit the application to SDBHS and CSH.
SDBHS reviews the application and completes any required public posting.
Developer/Sponsor continues to finalize the remainder of the application during this time
Applicant will meet with SDBHS designee to discuss the complete application.
Require more revisions
SDBHS designee will determine if they:
Reject the application
SDBHS Director signs the final application approvals for submission to CalHFA for underwriting and funding approval

ATTACHMENT ONE: SAN DIEGO COUNTY SNHP
DEVELOPMENT SUMMARY FORM

Developer:

Sponsor:

Name of Project:

Project Address (including parcel #):

Supervisor/Council District:

Status of Site Control:

Entitlement Status and Time Estimate to complete Entitlements:

Anticipated Date of Certificate of Occupancy:

Community Planning Group:

Any Contact made yet with local neighbors or planning group? If yes, please specify meeting dates and times.

Community Process Plan including potential meeting dates with community groups:

PAGE TWO OF TWO

Total number of units and bedroom types:

Total number of SNHP units and bedroom types:

Square footage by bedroom of SNHP units:

Type of Development:

☐ Rental ☐ Shared ☐ New Construction ☐ Acquisition/Rehab

Type of Building:

☐ Apartment ☐ Shared ☐ Condominium ☐ Single

☐ Other _____

Total Cost of the Development:

Total Cost of SNHP Units:

Amount of SNHP Funds Requesting:

Additional Comments:

Contact Information:

Name: _____

Company: _____

Phone: _____

Fax: _____

Email: _____

Attachment Two - Recommendations and Guidelines

Recommendations to Develop a Variety of MHSA Housing Opportunities

1. MHSA Housing Program eligible clients ("clients") will choose and direct their housing arrangements.
2. MHSA units are prioritized for integrated housing/mixed population and/or mixed-income buildings housing a range of tenant populations. To ensure client choice, SDBHS should seek to achieve a mix of building types.
3. MHSA housing should be located in neighborhoods that meet the needs of the clients, including safety and security. Security design features such as architectural and landscape security design configurations, cameras in common areas, secured entry, and/or security services should be used to the extent possible.
4. SDBHS, CSH, the San Diego Housing Federation, and the FSP/BHS providers will work with affordable housing developers to secure units dedicated to clients in their housing projects.

MHSA Housing Project Development Guidelines

For shared and rental housing projects developed using MHSA housing funds, the following guidelines shall apply.

1. SDBHS intends to provide housing that is affordable to the client population served. MHSA Housing Program eligible clients will pay no less than 30% of their income for housing (and no more than 50% of their income).[1]

2. Clients will live in housing where they have their own bedrooms.

3. Shared housing may be eligible for funding under the condition that clients have their own lockable bedrooms. All shared housing projects will require the review process outlined in 8 below.[2]

4. While buildings may be of any size, SDBHS must ensure that a variety of projects are developed, that efforts are made to minimize concentration of clients, and that some projects funded are mixed population/ mixed-income tenancy and some projects are small in size (25 units or less.) Projects

[1]CSS planning guidelines from the State Department of Mental Health require housing affordability for MHSA clients living in MHSA supportive housing, meaning that each tenant pays no more than 30% to 50% of household income towards rent.

[2] The Mental Health Housing Ad Hoc Committee recommended removal of language that stated that shared housing for the transition-age youth (TAY) clients was not recommended. The idea of shared housing was discussed at all of the FSP client focus groups that were held in March 2009, including the TAY focus group. The results of the focus groups highlighted the importance of client choice, including both rental and shared housing. Although many clients expressed the desire to have their own apartment, some clients, including some TAY, did express a desire to share an apartment or house with a roommate, granted that they had their own bedroom. All shared housing will still go through the Project Exception Committee for review.

proposed that have more than 25 MHSA units, but the MHSA-dedicated units represent less than 10% of the total development, do not need to go through the Project Exception Committee. If the development has more than 25 units and it represents more than 10% of the total development, the project shall be evaluated under the process outlined in 9 below.[3]

5. MHSA-supported housing developments must be located near transportation. In addition, projects should have access to health services, groceries and other amenities such as public parks and/libraries.[4]

6. Studio apartments dedicated to individual clients should be designed for unit livability, meaning the space in the unit can accommodate the potential number of occupants and the basic pieces of common furniture necessary for daily activities. Units must at minimum include a bathroom and food preparation area. Studio units less than 350 square feet will be evaluated under the process outlined in 9 below. Rental Single Room Occupancy (SRO) units with shared bathrooms are not desirable and should not be funded.

   Due to the crisis of homelessness and the need to create housing opportunities quickly, projects that convert hotel/motels, and which may have units smaller than 350 square feet, and bring units online within a year of application for SNHP funding will be prioritized and not required to follow the process outlined in 9 below.

7. MHSA-supported housing developments should include sufficient community space, which could include the following: common meeting spaces, communal kitchens, computer room, and gardens. Dedicated space for services delivery is desirable, particularly in projects with higher numbers of MHSA units. Refrigerators should be at least "apartment size" refrigerators to allow for adequate food storage. It is also desirable for developments to have laundry facilities on-site.

8. Developments should have a plan for tenants in the event of an emergency. The emergency plan should be sent to the County prior to certificate of occupancy and it should be shared with tenants shortly after tenants move-in. The plan must include steps for helping tenants that need assistance in exiting the building.

9. For any proposed housing project (not including hotel/motel conversions), if guidelines 1 through 8 are not met, the Project Exception Committee of SDBHS staff, CSH, BHS Housing Council members, clients and family members will review the proposed project's design and provide input to the developer and

[3] The Mental Health Housing Ad Hoc Committee recommended that instead of proposed projects with more than 25 units being evaluated by the Project Exception Committee, it is recommended that if the project has more than 25 MHSA units but they are less than 10% of the total development then the project does not need to go through the Project Exception Committee. This change was in consideration of larger developments where 25 units may represent a small percentage of the total units in a development.
[4] At minimum, public transit that comes with reasonable frequency must be accessible within 0.5 mile. It is preferred that, where possible, other services be walkable within 0.5 mile (e.g. not including physical barriers that prevent access by foot or public transit).

County Mental Health before the project is considered for approval. This committee will review the proposed projects in an expedited process to prevent any delays in funding applications.

10. MHSA Housing projects must involve client representatives and family members in the planning process for all new MHSA projects. The Full Service Partnerships/BHS contractors will organize client representatives and family members in a timely manner to provide feedback.[5]

11. MHSA funded units should be retained as dedicated for mental health clients for the maximum time possible, based on other funding requirements and continued need and availability of services. Affordability requirements should be as long as permissible, with a target goal of 55 years if financially feasible.

12. SDBHS reserves the right to establish standard criteria and timelines that projects must meet in order to remain in SDBHS' MHSA Housing Pipeline. SDBHS reserves the right to de-commit funding if there are delays in project implementation, changes to the financial structure, and/or changes to applicant status. Standard criteria will be shared with the community, including developers.

[5] The Mental Health Ad Hoc Committee reinforced the importance of client feedback for all new MHSA housing projects.

Attachment 3 - CalHFA SNHP Term Sheet

All CalHFA documents related to the Local Government Special Needs Housing Program can be found here:
http://www.calhfa.ca.gov/multifamily/snhp/index.htm

H. Glossary

Glossary

Affordable housing: A general term applied to public- and private-sector efforts to help low and moderate-income people purchase or lease housing. As defined by HUD, any housing accommodation for which a tenant household pays 30% or less of its income.

Area Median Income (AMI): A figure calculated by HUD based on census data, for specific size households in a specific area. The median income divides the income distribution into two equal groups, one having incomes above the median, and other having incomes below the median.

At risk of homelessness: An individual or family that is coming out of a treatment program, institution, transitional living program, half-way house or jail and has no place to go; is living in a situation where the individual / family is at great risk of losing their housing; is in need of supportive services to maintain their tenancy; or is living in an inappropriate housing situation (i.e. substandard housing, overcrowding, etc.).

Board and Care (B&C): A Board and Care is a Residential Care Home that is licensed by the State of California's Community Care and Licensing Department. A Board and Care is licensed to provide care and supervision and store and dispense medications for residents. The purpose of the B&Cs is to provide continued outpatient stability. In most B&Cs, the client shares a room.

Coordinated Entry System (CES): The system that ensures all people experiencing a housing crisis have fair and equal access, and are quickly identified, assessed for, referred, and connected to housing and homeless assistance based on their needs and strengths, no matter where or when they present for services. Move from being project focused to client focused and eliminates different forms and assessment processes, maximizes resources by matching highest need clients with most intensive resources, and increases coordination.

Case management: The overall coordination of an individual's use of services, which may include medical and mental health services, substance use services, and vocational training and employment. Although the definition of case management varies with the model it follows, local requirements and staff roles, a case manager often assumes responsibilities for outreach, advocacy, and referral on behalf of individual clients.

Chronically homeless: HUD defines "chronically homeless" as an individual or family who: (i) Is homeless and lives or resides in a place not meant for human habitation, a safe haven, or in an emergency shelter; (ii) has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least 1 year or on at least 4 separate occasions in the last 3 years; and (iii) has an adult head of household (or a minor head of household if no adult is present in the household) with a diagnosable substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability, including the co-occurrence of 2 or more of those conditions. Additionally, the statutory definition includes as chronically homeless a person who currently lives or resides in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital or other similar facility, and has resided there for fewer than 90 days if such person met the other criteria for homeless prior to entering that facility.

Clinical: Pertaining to standardized evaluation (through direct observation and assessment) and conducted with the intent to offer intervention/treatment.

Continuum of Care: Defined by HUD as "a community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximize self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness."

Disability Income: SSDI (Social Security Disability Income) offers cash benefits for people with disabilities who have made payroll contributions to the federal social security program while they were employed.

Dually diagnosed/Co-occurring Disorder: Terms used to describe individuals who are diagnosed with two different disorders, typically a combination of mental health and substance use diagnoses.

Fair Market Rent (FMR): Fair Market Rent is an amount determined by the U.S. Dept. of Housing and Urban Development (HUD) to be the cost of modest, non-luxury rental units in a specific market area. Generally, an "affordable" rent is considered to be below the Fair Market Rent.

Homeless: HUD defines literal homelessness as an: (1) Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution

Housing and Urban Development (HUD): The U.S. Department of Housing and Redevelopment, created in 1965 to administer programs of the federal government which provide assistance for housing for the development of the nation's communities.

Housing First: An approach to ending homelessness that centers on providing homeless individuals and families with housing as quickly as possible under a standard lease agreement, and then providing other services as needed. Housing First programs offer case management and wraparound services to promote housing stability and individual well-being on an as-needed basis.

HUD Homeless Management Information System (HMIS): A local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness.

Medi-Cal: The California Medicaid welfare program serving low-income families, seniors, persons with disabilities, children in foster care, pregnant women, and certain low-income adults.

Permanent Supportive Housing: Combines and links permanent, affordable housing with support services designed to help the tenants stay housed. Tenants have the legal right to remain in the unit, as defined by the terms of a renewable lease agreement.

Point in Time Count: A one-day count of sheltered and unsheltered homeless persons in a defined area.

Rapid Re-housing: An approach that focuses on moving individuals and families that are homeless into appropriate housing as quickly as possible.

Section 8: A rental subsidy that makes up the difference between what the low-income household can afford to pay for rent, and a contract rent established by HUD for an adequate housing unit. Subsidies are either attached to specific units in a property (project-based), or are portable and move with the tenants that receive them (tenant-based).

SSI (Supplemental Security Income): Federal cash benefits for people aged 65 and over, the blind or disabled. Benefits are based upon income and living arrangement.

Stakeholders: Individuals who have a vested interest in the outcomes or the process of a particular endeavor.

Stigma: Misperception that results in bias towards an individual or group.

Subsidy: Financial assistance from the government to make the cost of housing affordable based on the household income level.

Transition Age Youth (TAY): Youth and young adults age 18-24.

Appendix L

MHSA Issue Resolution Process

Mental Health Services Act (MHSA) Issue Resolution Process
Revised June 5, 2017

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), and the California Mental Health Planning Council (CMHPC) to seek issue resolution or to file a complaint or grievance.

San Diego County Behavioral Health Services has adopted an issue resolution process for filing and resolving issues related to Mental Health Services Act (MHSA) community program planning process, and consistency between program implementation and approved plans.

The County's Behavioral Health Services Division 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 avenue within the system. These avenues may include but are not limited to: the County Behavioral Health Director, County Behavioral Health Assistant Director, County Behavioral Health Deputy Directors, Behavioral Health Councils, County Compliance Officer, Consumer and Family Liaisons, Patient Advocacy Program, and Behavioral Health Provider.
- The MHSA issue shall be forwarded to the Consumer and Family Liaisons, RI International and NAMI San Diego for review within one (1) business day 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 County's MHSA Coordinator of the issue received while maintaining anonymity of the Issue Filer.
- 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 Behavioral Health 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 Behavioral Health 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

Sue Skube
NAMI San Diego
5095 Murphy Canyon Road, Suite 320
San Diego, CA 92123
(858) 634-6580
Email: sueskube@namisd.org or
https://namisandiego.org/cyf-liaison

Appendix M

MHSA and Criminal Justice Clients

FY 2017-18

Mental Health Services Act (MHSA) Funded Services for Justice System Involved Clients

Focus Population	Program	FY 17-18 MHSA Funding*	Component
Youth	**Multi-Systemic Therapy (MST)** serves justice system involved youth in the San Diego Unified School District. Multi-Systemic Therapy is an evidenced-based, intensive, family-oriented and community-based intervention for youth who meet the criteria for Conduct Disorder or Oppositional Defiant Disorder. In partnership with the Probation Department, the program assesses youth in the institution and expands services to youth in the community who have been screened and found to have mental health treatment needs.	$862,000	CSS
Youth	This program funds Probation Officer staff costs to oversee the administering and scoring of the **Massachusetts Youth Screening Instrument Second Version (MAYSI-2)**. The MAYSI-2 is a brief screening instrument (52 questions) designed to identify potential mental health needs of adolescents involved in the juvenile justice system.	$140,000	CSS
Youth	**Breaking Cycles** offers support to Probation youth within institutions from all regions of San Diego County. A new component of the program increased staffing to offer screening and programming for Commercially Sexually Exploited Children (CSEC) detained in Juvenile Hall and the Girls Rehabilitation Facility as they transition back into the community.	$350,000	CSS
Youth	**The Stabilization Treatment and Transition (STAT) Probation After-Hours** program funds Probation Officer positions, offering individual, group and family treatment for youth in juvenile detention facilities.	$278,554	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.	$1,404,058	CSS
Youth	**Detoxification Adolescent Group Homes** located in the North, East and South Regions provide up to 30 days of short-term residential alcohol and other drug treatment/recovery and ancillary services for adolescents who may have co-occurring disorder. Mental health clinicians provide co-occurring disorder identification and intervention.	$240,000	PEI
Youth	**Outpatient Perinatal Recovery Centers** are adding more mental health clinicians who provide co-occurring disorder identification and intervention. These women, who are generally involved in Drug Dependency Court, often come to treatment with their young children that also receive supportive mental health services through a mental health clinician that works with the caregiver and child.	$1,235,400	CSS
Youth	**Juvenile Court Clinic** provides assessment, medication management services and case management for juveniles involved in the Court system.	$847,000	CSS
Transition Age Youth (16 to 25)	**Catalyst** is a Full Service Partnership (FSP) and Assertive Community Treatment (ACT) program for transition age youth (TAY) who are homeless, may have been referred by jail services, have a serious mental illness (SMI), and who may also have a co-occurring substance use disorder.	$4,379,170	CSS
Adults	**Center Star** is a FSP ACT program countywide for 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	$5,814,528	CSS

*The funding amount represents the total MHSA dollars allocated to a particular program and does not address other funding sources (if applicable). Certain 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. July 25, 2017

Mental Health Services Act (MHSA) Funded Services for Justice System Involved Clients

Focus Population	Program	FY 17-18 MHSA Funding*	Component
	detention. An array of housing options is provided to enrolled clients.		
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.	$1,760,000	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, and short term case management for persons with SMI who have been referred by the Court for services.	$207,944	CSS
Adults	**Project In-Reach** provides 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**.**	$420,000	CSS
Adults	The **Psychiatric Emergency Response Team (PERT)** provides mental health consultation, case coordination, linkage and limited crisis intervention services for individuals with mental illness who come in contact with law enforcement officers.	$6,129,291	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.	$785,167	CSS
Adults	The **Behavior Health Assessor** is a pilot program for 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.	$311,500	CSS
Adults	The **BH Assessor** is a pilot 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 **Gateway to Recovery is a Full Service Partnership (FSP) Assertive Community Treatment (ACT)** program that provides multidisciplinary, wraparound treatment and rehabilitation services to persons with high service usage and persons on probation.	$3,055,060	CSS
Adults	The **Serial Inebriate Program (SIP)** is a collaborative effort involving the Courts, police, city and district attorneys, emergency medical services, health and human services, treatment providers, hospitals, sheriff deputies and the contracted program to treat chronically-homeless inebriates countywide. The SIP provides non-residential substance abuse treatment and case management services as an alternative to custody for court-sentenced individuals with co-occurring disorder.	$285,500	PEI
Adults	**Non-Residential Recovery Centers** provide clinicians who enhance co-occurring disorder identification and intervention. Clients are self-referred, or referred by probation, law enforcement or the Court.	$2,205,200	PEI
Adults	**Drug Court/Reentry Court** is an outpatient substance use disorder (SUD) treatment, case management and drug testing program services to serve adult offenders who have been referred to Re-Entry Court Services Program.	$885,000	Adults

*The funding amount represents the total MHSA dollars allocated to a particular program and does not address other funding sources (if applicable). Certain 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. July 25, 2017

Mental Health Services Act (MHSA) Funded Services for Justice System Involved Clients

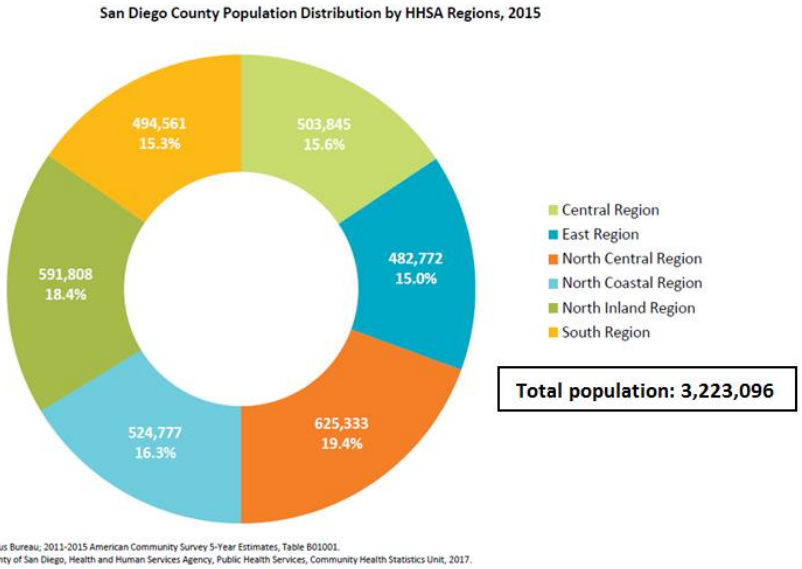
Focus Population	Program	FY 17-18 MHSA Funding*	Component
Adults	**Faith Based - Wellness Ministry** is a program that focuses on adults diagnosed with SMI while in jail and also engages individuals with schizophrenia or bipolar disorders to provide spiritual support, mental health and physical health wellness education, and linkages to community-based resources for reintegration into the community.	$206,665	Adults
Adults	**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.	$1,000,000	Adults
Grand Total		**$33,237,037**	

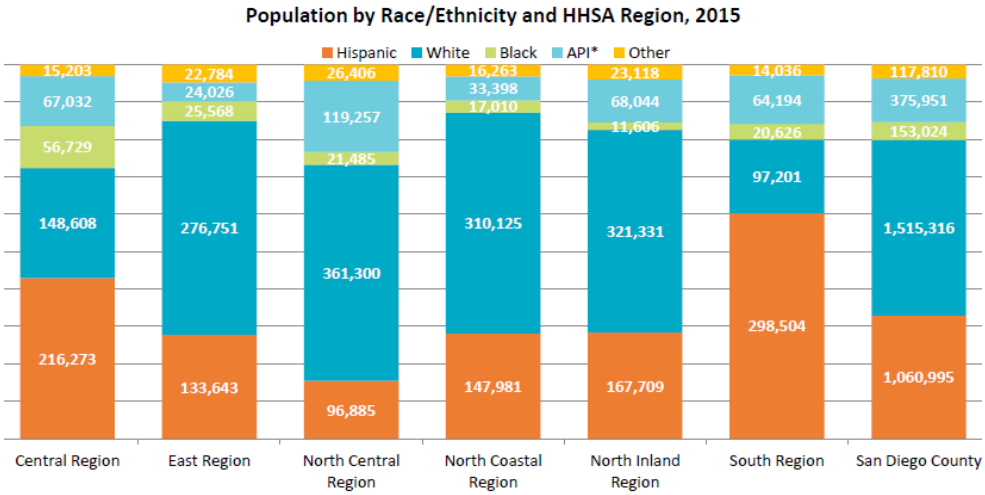
*The funding amount represents the total MHSA dollars allocated to a particular program and does not address other funding sources (if applicable). Certain programs may also serve non-justice system involved clients. Programs for the general population that also serve justice system involved clients are not included in these totals. July 25, 2017

Appendix N

County of San Diego Demographics

County of San Diego Demographics



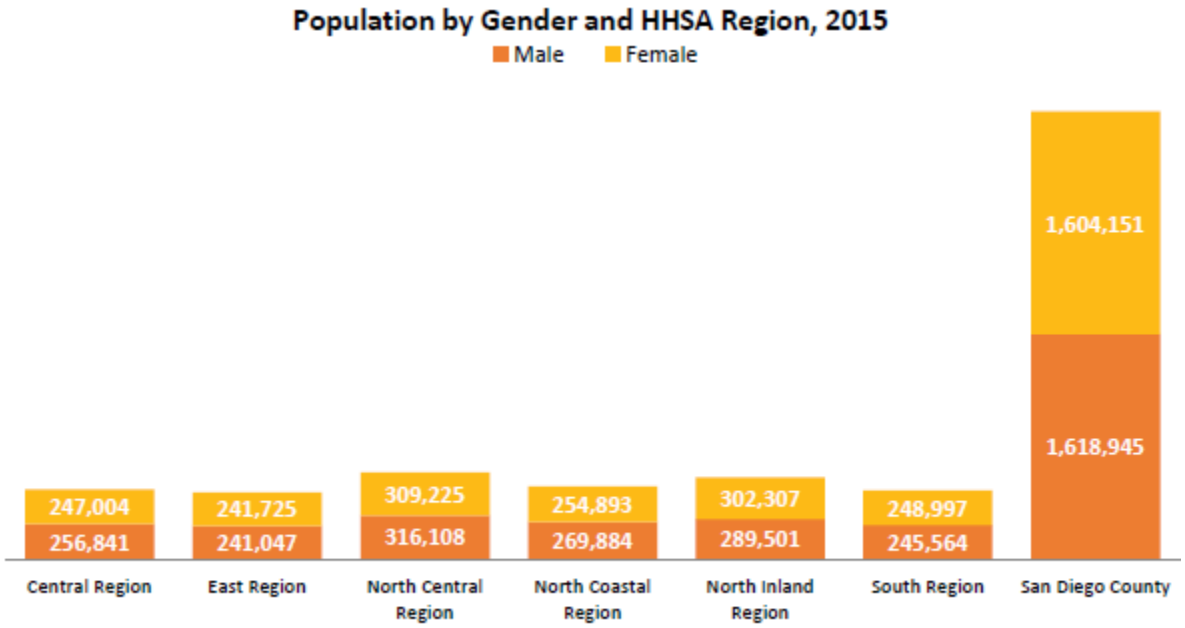


*API refers to Asian/ Pacific Islanders and include Asian, Pacific Islander, and Native Hawaiian. Other includes American Indian or Alaska Native, 2 or more races, and other.

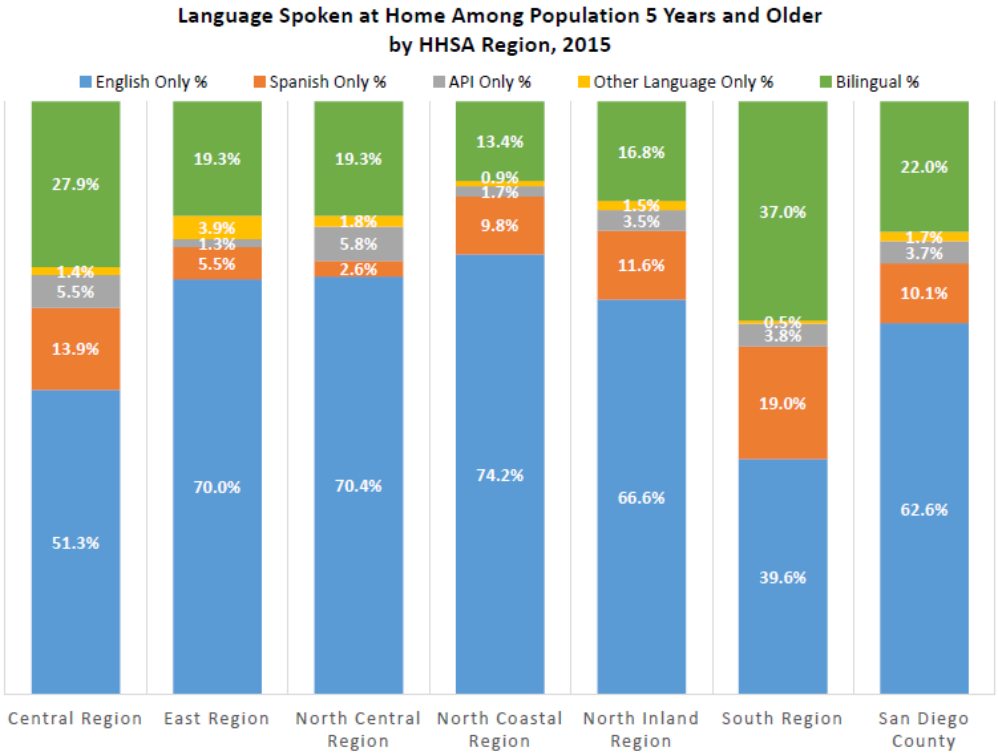
Source: U.S. Census Bureau; 2011-2015 American Community Survey 5-Year Estimates, Table B03002.

Prepared by: County of San Diego, Health and Human Services Agency, Public Health Services, Community Health Statistics Unit, 2017.

SAN DIEGO COUNTY DEMOGRAPHICS



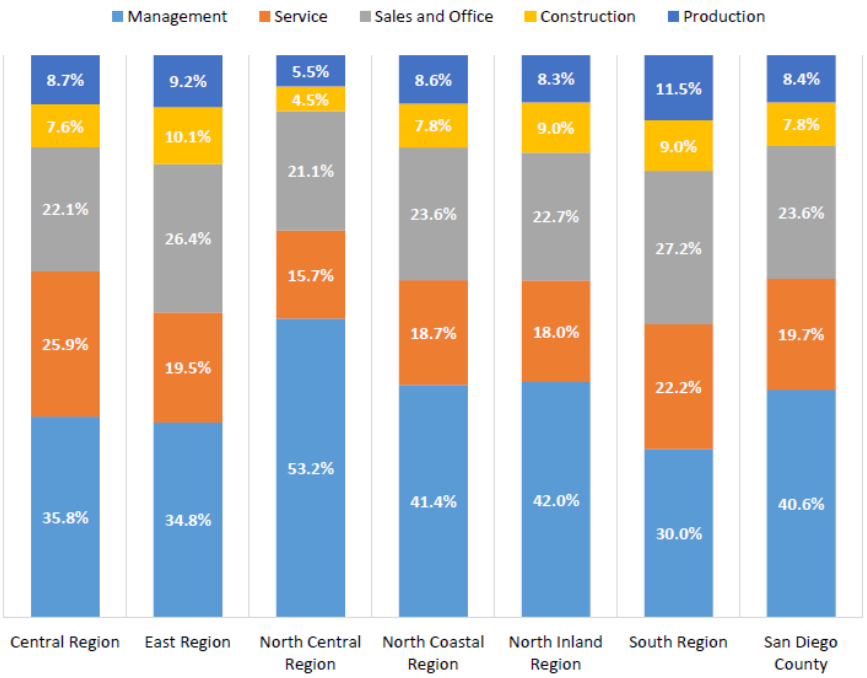
Source: U.S. Census Bureau; 2011-2015 American Community Survey 5-Year Estimates, Table B01001.
Prepared by: County of San Diego, Health and Human Services Agency, Public Health Services, Community Health Statistics Unit, 2017.



Source: U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates, Table DP02.
Prepared by: County of San Diego, Health and Human Services Agency, Public Health Services, Community Health Statistics Unit, 2017.

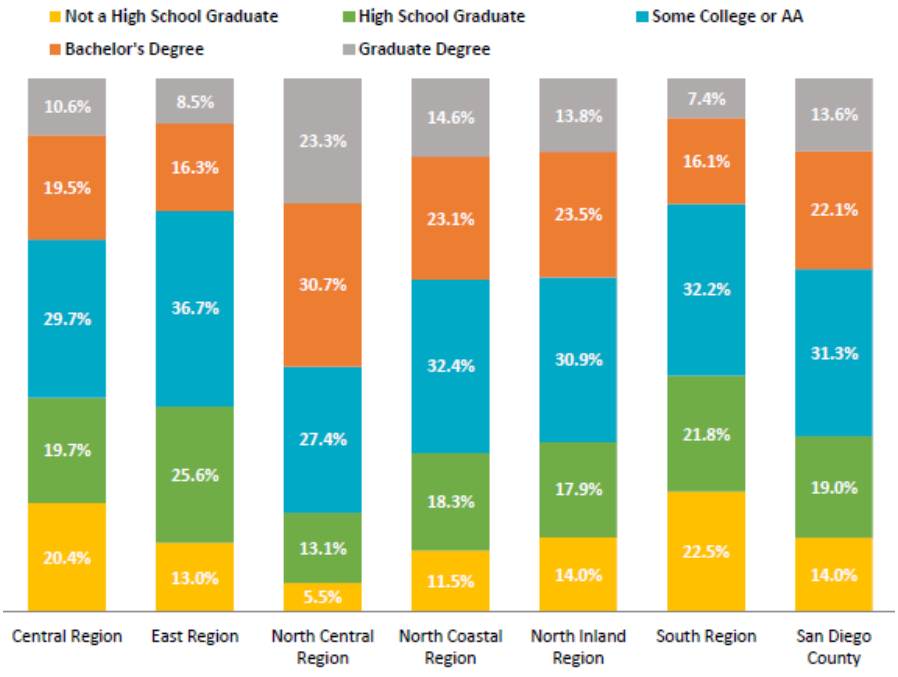
SAN DIEGO COUNTY DEMOGRAPHICS

Labor Force by Occupation by HHSA Region, 2015



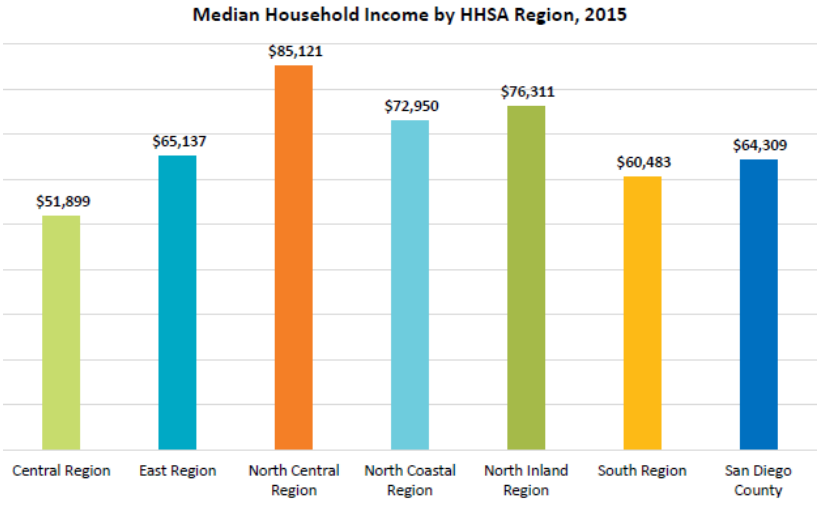
Source: U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates, Table DP03.
Prepared by: County of San Diego, Health and Human Services Agency, Public Health Services, Community Health Statistics Unit, 2017.

Education Attainment Among Population 25 Years and Older by HHSA Region, 2015



Source: U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates, Table DP02.
Prepared by: County of San Diego, Health and Human Services Agency, Public Health Services, Community Health Statistics Unit, 2017.

SAN DIEGO COUNTY DEMOGRAPHICS



Source: U.S. Census Bureau; 2011-2015 American Community Survey 5-Year Estimates, Table DP03, DP04.
Prepared by: County of San Diego, Health and Human Services Agency, Public Health Services, Community Health Statistics Unit, 2017.

†See *Supplemental Page* for more related data.
LWSD = Live Well San Diego Indicator

San Diego County

Overview

Demographic Profile (U.S. Census Bureau; 2011-2015 American Community Survey [ACS] 5-Year Estimates)

	Number	Percent
Total Population	3,223,096	100%
Age Distribution		
0 to 4 Years	210,874	6.5%
5 to 14 Years	394,489	12.2%
15 to 24 Years	489,299	15.2%
25 to 44 Years	939,172	29.1%
45 to 64 Years	791,588	24.6%
65+ Years	397,674	12.3%
Gender Distribution		
Male	1,618,945	50.2%
Female	1,604,151	49.8%
Race/Ethnicity		
White	1,515,316	47.0%
Hispanic	1,060,995	32.9%
Black	153,024	4.7%
Asian/Pacific Islander	375,951	11.7%
Other	117,810	3.7%

Income (2011-2015 ACS)	Number	Percent
Total Households	1,094,157	100.00%
Household Income		
< $35,000	298,794	27.3%
$35,000 to $50,000	132,483	12.1%
$50,000 to $75,000	186,692	17.1%
$75,000 to $100,000	141,431	12.9%
$100,000 to $150,000	173,540	15.9%
> $150,000	161,217	14.7%
Income per Person in HH		
Median HH Income		$46,461
Persons Per HH		2.65
Income per Person in HH		$24,229

Unemployment Estimates (2011-2015 ACS)	
Eligible Labor Force	
16+ Years	2,579,342
Labor Force	
Percent Unemployed	8.3%**

Occupation (2011-2015 ACS)

Labor Force (16+ Years)	
Unemployed Civilians	139,302
Armed Forces	75,665
Employed Civilians	1,462,130
Employed Civilian Occupation Category (16+ Years)	
Management, Professional, & Related	40.6%
Service	19.7%
Sales and Office	23.6%
Construction, Extraction, & Maintenance	7.8%
Production, Transportation, & Material Moving	8.4%

Industry (2011-2015 ACS)

Industry of Civilian Employees	
Agriculture, Forestry, Mining	1.0%
Construction	5.5%
Manufacturing	9.4%
Wholesale Trade	2.5%
Retail Trade	11.1%
Transportation, Warehousing, and Utilities	3.7%
Information and Communications	2.3%
Finance, Insurance, and Real Estate	6.3%
Professional, Scientific, Management, Admin.	14.5%
Educational, Social and Health Services	21.3%
Entertainment and Hospitality related	11.7%
Other Services	5.3%
Public Administration	5.5%

Education (2011-2015 ACS)	
Total Population	
25+ Years Old	2,128,434
Completed Education	
< High School Graduate	14.0%
High School Graduate	19.0%
Some College or AA	31.5%
Bachelor Degree	22.1%
Graduate Degree	13.6%

School Enrollment (2011-2015 ACS)

Population Eligible for Enrollment	
4 to 18 years	605,241
Private vs Public School Enrollment	
Percent Public Schools	92.1%
Percent Private Schools	7.9%

Language (2011-2015 ACS)

Total Population	
5+ Years Old	3,012,222
Primary Language Spoken at Home	
English Only	62.6%
Spanish Only	10.1%
Asian/Pacific Island Language Only	3.7%
Other Language Only	1.7%
Bilingual	22.0%

Housing Estimates (2011-2015 ACS)

Occupancy	
Owner Occupied	49.0%
Renter Occupied	43.6%
Housing Costs	
Median House Value	$429,600
Median Rent	$1,344

Personal Vehicles (2011-2015 ACS)

Household Vehicle Availability	
No Vehicle	6.1%
1 Vehicle	31.8%
>1 Vehicle	62.00%

Poverty Estimates (2011-2015 ACS)

Income Percent of Poverty Level	
<50%	7.1%
50 - 74%	3.0%
75 - 99%	4.4%
100 - 124%	4.4%
125 - 149%	4.7%
150% - 199%	9.1%
200% +	67.3%
Percent Below Poverty Level	
Population	14.5%
Families	10.6%
Families With Children	15.3%

Total Family Households	
With Children <18 Years	334,679
Families With Children <18 Years	
Percent Single Parent	28.2%

**= Percent unemployed of the 16 year and older eligible labor force

San Diego County

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Marital Status (2011-2015 ACS)

	Number	Percent
Total Population		
15+ Years Old	2,617,733	81.3%

Marital Status	
Single, Never Married	35.6%
Married	47.2%
Separated	1.9%
Widowed	4.9%
Divorced	10.3%

Public Program Participation (2011-2015 ACS)

Food Stamps/SNAP/CalFresh Benefits	
Households	6.7%
Families with Children	6.8%
Eligibility by Federal Poverty Level (FPL)	
Population ≤130% FPL	20.0%
Population ≤138% FPL	21.5%
Population 139% - 350% FPL	32.9%

Selected Status Populations (2011-2015 ACS)

	Number	Percent
Disability Status		
With a Disability	301,597	9.7%
With a Hearing Difficulty	85,795	2.7%
With a Vision Difficulty	53,120	1.7%
With a Cognitive Difficulty	119,153	4.1%
With an Ambulatory Difficulty	155,151	5.3%
With a Self-care Difficulty	65,828	2.3%
With an Independent Living Difficulty	123,789	5.2%
Veteran Status		
Veteran Population	233,863	9.7%
Foreign Born		
Total Population	3,233,096	100.00%
Foreign Born	758, 527	23.5%
Foreign Born, Naturalized Citizen	373,456	11.6%
Foreign Born, Not a U.S. Citizen	385,071	11.9%

Selected Housing Characteristics (2011-2015 ACS)

	Total Units	Occupied
Housing and Occupancy		
Total Housing Units	1,176,046	1,115,961
Single Family - Detached	551,255	531,442
Single Family - Multiple-Unit	157,773	148,715
Multi-Family	424,548	397,017
Mobile Home and Other	42,470	38,787

Older Adult Population (2011-2015 ACS)

Total Population	
65+ Years Old	397,674
Household Type	
Married-Couple Family	54.1%
Family Household, No Spouse Present	15.6%
Non-Family Household	4.2%
Group Quarters	2.6%
Male, Living Alone	7.3%
Female, Living Alone	16.2%
Poverty	
Percent Below 100% FPL	9.2%
Percent Below 200% FPL	26.8%
Income	
Mean Household Earnings	$87,081
Percent with Earnings	80.3%
Percent with Social Security Income	24.9%
Percent with Supplemental Security Income	4.8%
Percent with Cash Public Assistance Income	2.7%
Percent with Retirement Income	17.5%
Percent with Food Stamps/SNAP Benefits	6.7%
Labor Force	
Percent in Labor Force	16.9%
Grandparents	
Living with Grandchild (<18 Years Old)	47,362
Responsible for Grandchild (<18 Years Old)	46.4%

Selected Economic & Social Characteristics (2011-2015 ACS)	
Monthly Housing Costs as a Percentage of Household Income	
Less than 20% per Month	32.2%
20% to 29% per Month	23.1%
30% or more per Month	44.6%
Health Insurance Coverage Status	
Ages 0-17 Years	
With Health Insurance Coverage	92.9%
Without Health Insurance Coverage	7.1%
Ages 18-24 Years	
With Health Insurance Coverage	77.2%
Without Health Insurance Coverage	22.8%
Ages 25-44	
With Health Insurance Coverage	78.1%
Without Health Insurance Coverage	21.9%
Ages 45-64	
With Health Insurance Coverage	85.5%
Without Health Insurance Coverage	14.5%
Ages 65+	
With Health Insurance Coverage	98.4%
Without Health Insurance Coverage	1.6%
Commute to Work	
Car, Truck, or Van - Drove Alone	76.0%
Car, Truck, or Van - Carpooled	9.3%
Public Transportation (Excluding Taxis)	3.0%
Walked	2.72%
Other Means	1.84%
Worked from Home	6.26%

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 – Behavioral Health Services
BPSR – Biopsychosocial 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
CF – Capital Facilities
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
EMASS – Elder Multicultural Access and Support Services
ESU – Emergency Screening Unit
FPP – Federal Financial Participation
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
IMR – Illness Management Recovery
INN – Innovation

LGBTQ - Lesbian, Gay, Bisexual, Transgendered, and 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 Improvement 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

MHSA Stakeholder Feedback

P - MHSA Stakeholder Feedback PLACEHOLDER